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ABSTRACT

This document contains testimony and prepared statements from assistant secretaries in the Department of Education and the Department of Health and Human Services; directors from the Department of Health and Human Services; the general director of Beth Israel Medical Center; the president of Phoenix House Foundation, Inc., a drug-free treatment program with services in New York and California; the executive director of the Alcohol and Drug Problems Association of North America; representatives from the New Jersey State Department of Health, police departments, schools, and the State Department of Education. Activities of the Department of Health and Human Services and the Department of Education are reviewed to examine their responses to the concerns of state and local treatment and prevention professionals. Reports are included on the current situation from treatment and prevention experts. The role of methadone maintenance in treating drug addiction is examined, and drug-free treatment alternatives are explored. Testimony is also given from a panel of state and local representatives from New Jersey involved in the statewide community organization program (SCOP), a community-based drug abuse prevention approach which has successfully increased school attendance, encouraged youth volunteer services, and reduced vandalism and other disruptive behaviors associated with drug abuse. (NRB)

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# DRUG ABUSE TREATMENT AND PREVENTION—1984

ED255824

## HEARING

BEFORE THE

## SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

SECOND SESSION

JUNE 26, 1984

Printed for the use of the
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# CONTENTS


| | Page |
|---|---|
| Testimony of Dr. Lawrence F. Davenport, Assistant Secretary for Elementary and Secondary Education, Department of Education | 3 |
| Testimony of Dr. Edward N. Brandt, Jr., Assistant Secretary for Health and Human Services | 4 |
| Testimony of Daniel Michels, Director, Office of Compliance, Center for Drugs and Biologics, Food and Drug Administration, Department of Health and Human Services, accompanied by Dr. James R. Cooper, Director, Division of Medical and Professional Affairs, National Institute on Drug Abuse, Department of Health and Human Services | 36 |
| Testimony of Dr. Robert G. Newman, general director, Beth Israel Medical Center, New York, NY | 40 |
| Testimony of Dr. Mitchell S. Rosenthal, president, Phoenix House Foundation, Inc., New York, NY | 58 |
| Testimony of Karst J. Besteman, executive director, Alcohol and Drug Problems Association of North America | 69 |
| Testimony of Charles Currie, chief of prevention, Division of Narcotic and Drug Abuse Control, New Jersey State Department of Health | 76 |
| Testimony of Gale Kavanagh, SCOP coordinator, Division of Narcotic and Drug Abuse Control, New Jersey State Department of Health | 77 |
| Testimony of Detective Sgt. Donald Stumpf, Juvenile Division, Bergenfield Police Department, Bergenfield, NJ, SCOP team member, Bergenfield | 81 |
| Testimony of Josephine Zambrana, SCOP team member, Franklin School, Newark, NJ | 83 |
| Testimony of Dr. Walter McCarroll, assistant commissioner of education, New Jersey State Department of Education, and SCOP team member, Sparta, NJ | 86 |
| Opening statement by Chairman Charles B. Rangel | 91 |
| Statement by Lawrence F. Davenport | 92 |
| Statement by Edward N. Brandt, Jr., M.D. | 93 |
| Statement by Daniel L. Michels | 98 |
| Statement of Robert G. Newman, M.D. | 100 |
| Statement of Mitchell S. Rosenthal, M.D. | 103 |
| Statement of Karst J. Besteman | 106 |
| Testimony of Charles Currie on behalf of Richard J. Russo | 123 |
| Statement of Walter J. McCarroll | 152 |
| Appendix A—Fiscal year 1983 subcontracts recommended for funding by contractors | 154 |
| Appendix B—Letter of response from Robert G. Newman, M.D., Beth Israel Medical Center | 158 |

# DRUG ABUSE TREATMENT AND PREVENTION—1984

TUESDAY, JUNE 26, 1984

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
*Washington, DC.*

The select committee met pursuant to call, at 9:35 a.m., in room 2237, Rayburn House Office Building, Washington, DC, Hon. Charles B. Rangel, (chairman of the select committee) presiding.

Present: Representatives Charles B. Rangel, Daniel K. Akaka, Sam B. Hall, Jr., Benjamin A. Gilman, Lawrence Coughlin, and E. Clay Shaw, Jr.

Staff present: John T. Cusack, chief of staff; Richard B. Lowe III, chief counsel; Elliott A. Brown, minority staff director; George Gilbert, counsel; Michael J. Kelley, counsel; John J. Capers, chief investigator; Martin I. Kurke, researcher (Department of Justice detail); James W. Lawrence, minority professional staff; Iris Morton, ComSci Fellow; Catherine H. Shaw, minority professional staff; Karen E. Watson, professional staff; Lecia Eve, intern; Julie Croft, intern; and Jeff Isaacs, intern.

Mr. RANGEL. The Select Committee on Narcotics Abuse and Control will come to order.

This morning, our committee will conduct a hearing on drug abuse treatment and prevention issues. Our hearings, of course, in the country and in Washington, over the past year and a half, we have heard conflicting testimony as to whether drug abuse in America is increasing, decreasing, or leveling off.

Notwithstanding these differing views, a number of critical facts clearly emerge. First, drug abuse continues to be the most important, most serious public health and social problem that our Nation faces today.

Drug abuse costs cost our society an estimated $100 billion. Drug use has escalated dramatically over the past 2 years, particularly among our young people.

And remains at unacceptably high levels. It is thought that levels of drug use in the United States exceed those in other industrialized nations in the world.

From 1978 to 1982, cocaine related deaths and emergency room episodes jumped 300 percent and remained at high levels. Heroin related hospital emergencies rose nearly 80 percent nationally, and heroin overdose deaths increased almost 50 percent over the same period.

In the city of New York, heroin deaths rose from 246 to 528, a 115-percent increase that remains high.

Second, States and localities are increasingly unable to meet the growing demand for treatment and prevention services, which is especially true in many of our Nation's top urban areas that are the hardest hit by drug abuse.

Over 94 percent of the States responding to the 1983 survey conducted by the National Association of State Alcohol and Drug Abuse Directors, reported an unmet need for treatment and prevention services in their States.

New York City has a waiting list of over 1,500 people who have sought treatment and been turned away because no space is available.

According to a recent survey by the National Associations of City Drug and Alcohol Coordination, many cities report reductions in treatment and prevention services, waiting lists and gaps in services, and existing programs are heavily overutilized.

Third, there is a strong feeling among State and local drug abuse treatment and prevention professionals that the Federal Government has abdicated its leadership responsibilities in this area.

Federal funding for drug abuse services have decreased about 40 percent under the Alcohol, Drug Abuse and Mental Health Service block grant. State and local revenue and private resources have not been sufficient to fill the gap created by Federal budget cuts, leaving many States with the difficult prospect of trying to do more with less.

Technical assistance, public administration activities and other forms of Federal support have also been cut back significantly.

In the words of one witness, the abrupt reduction in the level of Federal contributions to prevention and treatment amounts to a simple abandonment by the Federal Government of the prevention and treatment field.

Today, the select committee will ask the Federal Government what it is doing to meet the growing demand for drug abuse treatment and prevention services, we will review the activities of the Department of Health and Human Services and the Department of Education to see how well they are responding to the concerns we have heard from State and local treatment and prevention professionals.

We also will hear reports on the current situation from treatment and prevention experts who are on the front line of our fight against drug abuse.

Another issue the committee will examine is the role of methadone maintenance in treating drug addiction. Methadone maintenance has been a controversial treatment modality. Questions have been raised regarding the safety and efficacy of methadone and whether it's appropriate to substitute one dependency on a drug for dependency on another.

On the other side, studies have demonstrated that clients who remain in methadone treatment centers show improvement in terms of employment and social functioning, decrease drug use and decrease their criminal behavior.

We will also look at drug-free treatment alternatives. Finally, the committee will hear from a panel of State and local representa-

tives from New Jersey, who are involved in the statewide community organization program. This community based drug abuse prevention approach has been successful in increasing school attendance, encouraging youth volunteer service and reducing vandalism and other forms of disruptive behavior associated with drug abuse.

We are anxious to learn more about this exceptional prevention effort.

I want to thank all our witnesses for taking the time and trouble to be with us today, and we look forward to your testimony.

[Mr. Rangel's opening statement appears on p. 91.]

We are joined by Congressman Akaka from Hawaii, one of the hardest working members we have in the Congress and on this committee, and I ask whether he has an opening statement.

Mr. AKAKA. Thank you very much, Mr. Chairman.

I want to also welcome the guests and associate myself with your remarks. Thank you very much.

Mr. RANGEL. Well, Dr. Brandt and Dr. Davenport, you have both heard the opening statement. I assume that our staffs have told you in advance some of the questions that we'd like to have answered. So you may proceed with your prepared testimony or any way you find comfortable, to deal with the problems that have been presented to you.

Dr. DAVENPORT. Mr. Chairman, if you would enter my official statement for the record, I'd like to give you a summary of it.

Mr. RANGEL. Very well. Without objection, your full statement will appear in the record.

## TESTIMONY OF DR. LAWRENCE F. DAVENPORT, ASSISTANT SECRETARY FOR ELEMENTARY AND SECONDARY EDUCATION, DEPARTMENT OF EDUCATION

Dr. DAVENPORT. Mr. Chairman and members of the committee, I am pleased to appear before you as part of this panel to discuss the Federal role in drug abuse treatment and prevention and education.

As you are aware, the Department of Education is the sole Federal agency with a broad mandate to work with the Nation's schools. The Department's organizational predecessor had 12 years of experience in developing school based alcohol and drug abuse education programs.

The primary role of the Department in this area is to provide leadership, training and technical assistance to the school systems for the purpose of developing local school capacity to deal with local alcohol and drug abuse problems using local resources.

The Department of Education supports the Alcohol and Drug Abuse Education Program, which assists schools and communities to deal with the problems of alcohol and drug abuse.

This program has five regional training centers and maintains a national network for training, dissemination and technical assistance.

Currently, 500 local schools and State agencies located throughout the country are part of the network. Each regional training center as a part of the scope of work provides technical assistance to State agencies and local school systems.

I will be happy to respond to any questions you may have. Thank you, Mr. Chairman.

[Prepared statement of Dr. Davenport appears on p. 92.]

Mr. RANGEL. Well, we raised a lot of questions. Thank you.

Dr. Brandt?

**TESTIMONY OF DR. EDWARD N. BRANDT, JR., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Dr. BRANDT. Yes, sir. Thank you very much, Mr. Chairman and members of the committee. I appreciate your invitation to appear today to discuss the Department of Health and Human Services' support of drug abuse treatment and prevention.

We are committed to both supply and demand reduction activities working toward the goal of reducing drug abuse in our society. Each of the past 3 years, nearly $1 billion of Federal funds, exclusive of block grant funds, have been directed toward this goal.

Within the Department of Health and Human Services, we conduct research, disseminate information, both to the drug abuse community and to the public, and through the block grant program, support State efforts for those who are currently afflicted by drug abuse and to help prevent others from abuse of drugs.

To this end, the President's fiscal year 1985 budget request would fund the alcohol and drug abuse and mental health services block grant at $472.3 million. Similarly, the request for research activities by the National Institute on Drug Abuse is $63.5 million, which represents the largest percentage increase for any categorical programs in the public health service.

In my testimony, Mr. Chairman, we have briefly summarized the dimensions of the drug problem and our efforts to deal with it. But, I think it is important to point out that as drug abuse is a major public health problem which has unique characteristics.

In the first place, drug abuse patterns change very rapidly. Secondly, unlike any other disease we face, there are illegal and highly profitable activities undertaken worldwide to actively promote drug abuse.

The current levels of drug abuse by youngsters and young adults represent a totally new phenomenon as far as health epidemics are concerned, and I have outlined in the testimony some aspects of that.

But, I'd like to point out one positive side, and that is that two out of three Americans have never used any of the drugs that are abused.

Mr. RANGEL. Is this a result of the Federal Government's efforts?

Dr. BRANDT. Well, I think it's probably a result, sir, of not only of the Federal Government's efforts, but also of the basic word that the American people have received that drug use and abuse is, in fact, harmful.

Mr. RANGEL. And, one out of three are abusers?

Dr. BRANDT. No, one out of three have some drug abuse----

Mr. RANGEL. I've just never heard it described the way you did. That's good news, that two out of three are not abusers, but that's very interesting.

Dr. BRANDT. Well, that's—I think that one has to remember, as we focus on the bad side, that, in fact, we still have a large proportion of the American population that aren't users, which is in itself a good sign.

Mr. RANGEL. Very good, doctor.

Dr. BRANDT. In terms of the number of abusers nationwide, use of many drugs has begun to decrease. We have documented this through a number of surveys, including our high school seniors' survey, national household survey and so forth.

However, although the percentages of new and current users of most drugs are decreasing or leveling off, adverse consequences associated with drug use continue to increase. This results in the appearance of seemingly contradictory trends—a decrease in the overall number of users, but an increase in the number who are addicted and need treatment, and in the number of medical complications and drug related deaths, as reported by hospital emergency rooms and medical exams.

Use of cocaine has begun to show signs of leveling off among high school seniors, but, again, medical emergencies associated with more intense use of this drug, including intravenous use and smoking, are increasing at an alarming rate.

The situation is highly variable from State to State and locality to locality, and among various user groups. For these reasons, we believe the block grant is the right mechanism to approach and address these diverse needs.

This restructuring of Federal assistance came from our conviction that States are better able to allocate funds for health programs within their boundaries than is the Federal Government.

Early results of studies conducted by the Urban Institute and the General Accounting Office indicate that States are effectively and efficiently using these funds to address their own unique health care problems.

As you know, under current law, States must expend 20 percent of their alcohol and drug abuse block grant allotment for prevention and early intervention. As the department indicated in our report to Congress, most States increased their emphasis on prevention programming through a variety of activities.

We have received a copy of a report prepared by the National Association of State Alcohol and Drug Abuse Directors entitled "State Resources and Services Related to Alcohol and Drug Abuse Problems." This report indicates that approximately $144 million was allocated by States for prevention services in fiscal year 1983, of that approximately $50 million is from Federal funding.

The principal departmental role in prevention research and prevention information development and dissemination has been to develop tests and evaluate new prevention and intervention strategies and to disseminate these results to State and local governments, the private sector, and other interested groups.

School-based preventive intervention research is a major focus of our prevention activities. Our research is focused primarily on programs for middle school and junior high school age students, the age groups in which vulnerability to drug use begin.

However, programs for senior high school students are also under study.

As promising approaches are ready for dissemination, we will conduct research on how best to achieve widespread adoption of these approaches by our Nation's schools.

Over the past 2 years, the National Institute on Drug Abuse has refocused its public education activities to reach a broad national audience. Two national media campaigns were developed in fiscal year 1982, designed, through a broad range of media material, to get across the drug abuse prevention message to parents and young people.

Continuation of this campaign in fiscal year 1984 will reinforce the parent and youth theme for the general population and highlight these themes through appropriate materials for special target audiences including the black and Hispanic communities.

Last year, we also worked with the National Broadcasting Company, with Peoples Drug Stores, a large drug store chain, and I have examples of the materials that were disseminated through that effort, which I would like to submit for the record.

[The information referred to is in the committee files.]

We also worked with the Scott-Newman Drug Abuse Prevention Award Program which through television activities tries to get this message across.

All of our prevention efforts build on a growing body of scientific knowledge about the health risks associated with drug abuse. These findings were consistent with and we believe largely responsible for the public's increased awareness that drugs are not the harmless or benign substances which many want to believe they are.

In fact, public attitudes about drug abuse have so changed in the past few years that our citizens now increasingly favor more vigorous enforcement of our drug laws.

Mr. Chairman, that concludes my formal statement. However, I would like to thank the select committee for the letter recently distributed to their House colleagues in opposition to the legalization of heroin—which, in our view, would, in fact, exacerbate our problems with drug abuse, and we believe that that letter was a marked contribution and I want to commend and thank you, and your counsels for that effort.

Thank you very much.

[Prepared statement of Dr. Brandt appears on p. 93.]

Mr. RANGEL. Dr. Pollin?

Dr. POLLIN. I'm just here for questions.

Mr. RANGEL. Dr. Davenport, you have heard my opening statement and I found some difficulty in seeing where the responses from your prepared testimony supplied the answers.

I would gather that there is no Federal education program as it relates to drug abuse at all.

Dr. DAVENPORT. No, sir. We have five regional training centers which I alluded to in my testimony. Over the years these centers have affected approximately 10 million young people across this country.

Mr. RANGEL. You train youngsters?

Dr. DAVENPORT. No, we train the teachers and principals to go back and work with the youngsters. Their programs then affect about 10 million young people.

Mr. RANGEL. That's not a Federal education prevention program; that is providing some assistance to teachers. But, that is one that was to say that we find the situation with drug abuse by youngsters to be bad and growing worse and some foreigner would ask the question, well, what is the Federal Government doing about it, in connection with education and prevention. Would the answer to that question, Dr. Davenport, be that the Federal Government is providing training for teachers on a regional basis?

Dr. DAVENPORT. It goes a bit further than that. The Federal Government is providing leadership and training the teachers who work with the young people in their school districts on the drug issues.

Mr. RANGEL. I wish you hadn't used the word leadership, because I will ask you to now describe the leadership that the Federal Government is giving as it relates to education and prevention of drug abuse, especially among American youngsters.

Dr. DAVENPORT. We can provide specifics for the record, but when you look at the efforts of the President and the First Lady, that the public statements of the President, the public statements of the First Lady, the statements of the Secretary of——

Mr. RANGEL. Let's talk about that, Dr. Davenport, because I've talked about this quite a bit. Now, what statements are you talking about that the President has made?

Dr. DAVENPORT. Statements regarding the issue of drug trafficking and trying to put a stop to it, the President's task force, which is chaired by the Vice President, the interagency task forces which are established——

Mr. RANGEL. You're talking about law enforcement?

Dr. DAVENPORT. All of those are part of the Federal effort.

Mr. RANGEL. Dr. Davenport, I am only talking about the effort that you have responsibility for, which is education, and it is shocking that you would include the President and the First Lady as a part of that educational program.

And, certainly we have hearings that deal with law enforcement and sanctions and prison systems, but I think it's safe to say that after you leave the First Lady in her television shows and the President and his statement, that when it gets back to the educational program and the leadership, that we're really talking about the Federal Government with some regional programs that train teachers to do what?

Dr. DAVENPORT. The teachers work with the young people in their community and start programs within their school systems to address drug abuse education. These programs are long lasting and have affected some 10 million young people in this country.

And, Mr. Chairman, it is significant when any program has worked with over 10 million young people in drug abuse education.

Mr. RANGEL. Well, they sure are working with them directly. I guess you could say that each Member of Congress works with some 500,000 people every day in view of the fact that they are our constituents. But I asked you, Doctor, if a foreigner was to come and ask you to identify the Federal programs that people can rely on, that our children can rely on, to assist the parents in the community in helping their children avoid drugs. Have you stated all the programs that are available?

Dr. DAVENPORT. No, sir. I said that there are 500 school districts right now, this year, involved in working on the drug issue. That is significant.

You may disagree, but that is significant. If you are in a school district which is sending five people to be trained in drug abuse education, and those people come back and train other teams to work on that issue in your school district, that is significant.

It may not be significant when we add up millions of dollars that we spend for other programs, but it's significant to that community and that school district.

Mr. RANGEL. Well, I would invite you to join with me to visit some of the school districts in the city of New York where clearly we have drug abusers that are youngsters on the street, where they can't get into clinics, that there is no assistance for them, and I would ask you to ask the principals and the superintendents of schools as to whether or not they are relying on any Federal programs to help.

What would a teacher do in the city of New York once he or she has been trained by the Federal Government to deal with some of the drug problems we have in central Harlem?

What are they trained to do?

Dr. DAVENPORT. I'd like to provide some of the examples of what they are doing for the record.

Mr. RANGEL. Well, Dr. Brandt has indicated that two out of three youngsters are clean. Now, what would your trained teachers do for the one out of three that is sitting up in the classroom as abusers?

Dr. DAVENPORT. They try to help the student get assistance to solve the problem.

Mr. RANGEL. In my opening statement, I said there was a waiting list of 1,500 adults in the city of New York. There are no programs for youngsters.

So, assuming that the teacher is dedicated and trained by the Federal agency, what can she or he do?

Dr. DAVENPORT. The key factor to understand is that this is a drug abuse prevention program. As a part of the prevention effort, the teams may help those who are already on drugs to become drug free through referral to appropriate programs and services.

There are some 65 teams for example, in Wichita, KS. We have now——

Mr. RANGEL. Let's get back to New York. A class of 60, 20 of them are drug abusers, and the teacher identifies them and she's trained by your office.

Dr. DAVENPORT. They would assist the young person to take advantage of all the resources which are available to address either drug prevention or for trying to get——

Mr. RANGEL. Dr. Brandt, you make a big issue about supporting the block grant. I'm not going to get involved in this area as to whether categorical grant or block grants are good because I think most governments would agree with you that they would like the discretion.

But, discretion with reduced funds and competing needs are not exactly what our governments were looking forward to when they supported the block grants.

After reviewing the block grant as relates to drug abuse education, prevention, and rehabilitation, do you reach the conclusion that there are less Federal dollars available to deal with this problem than when we had the categorical grant?

Dr. BRANDT. Well, there are less Federal dollars, but there are more total dollars. I think what we are seeing, since the mid-seventies, as the Federal programs have begun to level off, and——

Mr. RANGEL. Well, I know that we have to do more with less, but in your review, research of the problem, you have found a problem increasing in nature; is that correct?

Dr. BRANDT. As a general statement, we have seen the problem of drug use leveling off and decreasing in most parts of our society with——

Mr. RANGEL. But, where it's intense, we're finding more people dying from drug abuse; is that correct?

Dr. BRANDT. We find more people with medical complications from drug abuse, including death; that's correct.

Mr. RANGEL. So, in this great land of opportunity, we find that one out of three have abused drugs, and I'm asking you the question, do you believe that the Federal response to that should be less dollars to deal with the problem?

Dr. BRANDT. I believe that the Federal response to the problem ought to be those things that the Federal Government does best, and that includes education, and that includes research to develop techniques.

Mr. RANGEL. I thought we had finished on the question of education.

Dr. BRANDT. Well, you didn't ask what the Department of Health and Human Services is doing about education.

Mr. RANGEL. Oh, I'm terribly sorry. What are you doing in the area of education?

Dr. BRANDT. All right. I outlined a good bit of it in the detailed testimony, but we have done the following:

One, we have worked with PTA's and parents groups to try to educate them in the area of prevention, I'm now talking about giving them the kind of information that they, in fact, can use. That includes a complete summary of information about drug use for parents to use. For instance, the publication called "Parents, Peers and Pot."

We have also talked with community organizations that deal with these issues.

Mr. RANGEL. In the city of New York, what kind of staff have you got to educate the parents and the PTA's, and what group is at work with the parents? When I leave here and I want to tell the people that they are just not educated enough to identify the resources, the Federal resources are available, where would they go for this type of assistance?

Dr. BRANDT. We provide this kind of information through our clearinghouse on drug abuse. We also have——

Mr. RANGEL. Where would the clearinghouse be for the city of New York?

Dr. BRANDT. Well, it's in Washington for the entire United States.

Mr. RANGEL. Where is the clearinghouse?

Dr. BRANDT. It's located in Rockville, MD.

Mr. RANGEL. How would some mother in Harlem get some information from the clearinghouse to assist her——

Dr. BRANDT. She dials a toll-free 800 number which we have widely circulated throughout the country to talk to——

Mr. RANGEL. Dr. Pollin, to what degree have you found an increase in drug abuse to be targeted in black, Hispanic, and poor communities?

Dr. POLLIN. There is a differential change in drug abuse. While overall national prevalence is coming down, prevalence in ethnic minority communities is continuing at the same high level and we would not be surprised to see it increase.

Mr. RANGEL. Now, in your research, would you find that these areas are the same areas of high unemployment?

Mr. POLLIN. I suspect that that would be true, but our data thus far does not suggest a direct relationship between economic conditions on the one hand and drug use on the other.

We find that there are other factors, such as demographic changes, attitudes toward drugs, awareness of health consequences, family structure and the like——

Mr. RANGEL. Let me ask this. Would this normally be the type of community where people will be calling Washington or Rockville to ask for assistance for their children?

Dr. POLLIN. Well, that is only one of several avenues open, Mr. Chairman. But, if I might——

Mr. RANGEL. Could we strike out dropping a dime to Rockville and move onto the other avenues because I want to leave this hearing and having the members of this committee be better advised as to what Federal resources are available so that we can go back to our respective districts and say we are doing a job, and, Dr. Davenport has indicated that they are training teachers on a regional basis, Dr. Brandt has pointed out that there is a lot of information available to parents if they call Rockville, MD, and you are about now to tell me about the other resources that are available, aren't you?

Dr. POLLIN. I am, Mr. Chairman, but if you would permit me, I think that rather than limit our discussion merely to available resources and level of effort, in some ways, we're in a fortunate position with regard to changes in drug use patterns in that we have quite complete current trend data which show the consequences of the efforts we've made.

The changes which have taken place during the past 6 years in terms of changes in attitude, changes in perception of health risks, substantial increase in the percentage of people who are more negatively predisposed toward the use of drugs, and the parallel decreases in the numbers of people and especially the numbers of young people using drugs, gives us not only a measure of resources and level of effort, but a measure of the success to which Federal efforts, to some degree, have certainly contributed.

Mr. RANGEL. Well, Dr. Brandt made that abundantly clear, that we should be thankful that two out of three are not abusers. So, I'm not knocking the effort, I'm just saying, Could you share with me what tools you're using in order to have such a high batting average that would limit it to one kid out of three?

Dr. POLLIN. If I might just expand on that figure, the one out of three refers to people who have ever used. It does not include frequent use, the number who have abused or who are addicted would be considerably smaller.

Mr. RANGEL. Well, let me ask you, Dr. Pollin, since I have known you for a number of years and you are an expert in this field.

Do we have more drug abusers today than we had last year or the year before, the year before that? What is the trend in terms of drug abuse?

Dr. POLLIN. In my opinion, the overall trend nationwide is down.

Mr. RANGEL. By what percentage?

Dr. POLLIN. It varies with the drug. If we take the most widely abused drug, which is marijuana; focus on the number of abusers; and further focus on the serious abusers, those that were using daily or more frequently, that percentage has been cut in half since 1978.

To return to your prior question, Mr. Chairman, what activities and resources are we additionally involved in? We have been particularly concerned for a number of years about the possibility that prevalence and abuse would increase in ethnic minority communities because of the different demographics that we've referred to, and we'd like to submit for the record, some of our current and very recent activities to initiate major new efforts in ethnic communities.

We have helped to set up recently a black advisory group with representatives from the NAACP, the Urban League, Ministerial League, and other major black organizations, and hope to be able to help them in their autonomous efforts to initiate those kinds of community and family efforts in black communities that have been so successful in white middle class communities.

We are planning the same thing with Hispanic and American Indian groups, and we have high hopes for that effort.

Mr. RANGEL. Is there any inconsistency, Dr. Pollin, in what you've just told me and in the summary of testimony by Dr. Brandt where he indicates that there has been a steady increase in the use of all drugs among young people, not just a growing abuse of marijuana?

Dr. POLLIN. A steady increase in the abuse?

Mr. RANGEL. Maybe it's a typographical error, but this is what's attributed to Dr. Brandt's statement.

Dr. BRANDT. Well, that must be a typographical error because there is a steady decrease, not a steady increase. Where is that in my testimony?

Mr. RANGEL. It's the first page. It says, "the Department of Education, Health and Human Services work in conjunction with education preventive efforts, demographic or drug abuse that there has been a steady increase in the abuse of all drugs among young people, not just a growing abuse of marijuana.

"Bullet 2, 64 percent of all young people try an illicit drug before they finish high school." Do you have any problem with that statement?

Dr. BRANDT. No.

Mr. RANGEL. "Bullet 3, 1 in 18 high school seniors is actively using marijuana daily or nearly daily basis; 20 percent have done so for at least a month some time in their lives.

"Bullet 4, 1 in every 16 seniors is drinking alcohol daily. Over 40 percent have had five or more drinks," and the last bullet here, "one-third of the American household population over age 12 has used marijuana, cocaine, heroin, for nonmedical purposes at some time during their life, and then something which clearly is true in New York, there has been a sharp rise in medical emergency room incidents involving cocaine, marijuana, PCP, and heroin."

So, is that your statement?

Dr. BRANDT. Well,——

Mr. RANGEL. I mean, does it sound familiar as something that would come out of Health and Human Services?

Dr. BRANDT. Well, there is no question that if you look at the statement, in the period of time between the late fifties and the late seventies there was a steady increase in drug abuse.

Mr. RANGEL. You mean the statement relates to the late fifties——

Dr. BRANDT. No, sir, but, the statement—if you read the statement on page 2, it says that nearly a thirtyfold increase -the steady increase in drug abuse has not been limited to marijuana. We were talking about that period of time from the fifties to the seventies.

Mr. RANGEL. Do you have your summary in front of you because I——

Dr. BRANDT. Yes, sir, I do.

Mr. RANGEL. Pardon?

Dr. BRANDT. I have the statement in front of me, yes, sir.

Mr. RANGEL. I see. And, where did the staff get the remark that there's a steady increase in the abuse of all drugs and the doctor's saying that there is not a steady increase?

Dr. BRANDT. If you look on page 3 of my statement, right below all of those bullets, it says in terms of the number of users nationwide, use of many drugs has begun to decrease. That's what we have found in a number of our surveys. We agree with all of these bullets. There is no question that all of these have occurred. That nearly 2 out of every 3 young people try an illicit drug before they finish high school.

That's for sure—that happens.

Mr. RANGEL. Well, it seems as though, you know, I didn't let Dr. Davenport complete his statement that relates to law enforcement, but they claim that we got bumper crops coming in of cocaine and heroin and hashish and marijuana, and if there are less and less people using more and more that's coming in, somebody must be consuming it.

Dr. BRANDT. Well, I think that the issue when we deal with any kind of substance abuse and that includes smoking, alcohol, drugs, and so forth—that the heavy users continue. It is very difficult to get someone who is addicted to heroin or addicted to cocaine off those substances.

The issue is the difference between use, abuse, and addiction, and that's what we're attempting to clairify—that's where the numbers get confused.

Mr. RANGEL. We have 1,500 people in the city of New York trying to get help, and you believe that's a local problem?

Dr. BRANDT. Well, I believe that that certainly is a problem in New York City, yes, sir, and that is, therefore, in that sense, a local problem.

Mr. RANGEL. We find in the city of New York a backlog of 2,000 criminal cases that are drug related. Is that a local problem?

Dr. BRANDT. It's a local problem in that it involves New York City, sure.

Mr. RANGEL. OK. We find in New York City over half a million people addicted to drugs. Is that a local problem?

Dr. BRANDT. It is a problem that deals with a local area and one that requires a solution that involves all of us in trying to solve the problem.

Mr. RANGEL. And, some of our efforts to assist the city of New York as relates to education, prevention, and rehabilitation, it is the block grant which you believe is the best way to go about this, the training on the regional basis of some of our teachers, and the available information for those who call Rockville, MD?

Dr. BRANDT. Well, in addition to that, of course, we are, in fact, providing technical assistance in a variety of ways to State authorities should they request it or should they wish it.

We have tried to work recently with the city and State of New York to try to solve the methadone clinic backlog problem that you're referring. We have worked with those two governments for some time, particularly when the supply of heroin reportedly was beginning to go down and many of the heroin addicts showed up at methadone clinics in rather large numbers. We worked with them to try to solve that problem in a way that would allow the local governments to be as responsive as possible.

So, we are, in fact, trying to work with the local officials as they attempt to solve problems that occur in their areas of responsibility, and we will continue to do so.

Mr. RANGEL. Do you still believe that there should be any Federal programs or Federal presence as it relates to drug education, prevention, and rehabilitation?

Dr. BRANDT. I think we have a Federal presence in that, and I think that our presence is, in fact, the primary source of educational and prevention information. In fact, the national——

Mr. RANGEL. Where is the presence? Through the block grant?

Dr. BRANDT. Well, you're talking about dollars, or you're talking about information?

Mr. RANGEL. I'm talking about someone asking their Congressman. They have a kid that's addicted to drugs or he's using drugs, and they want to go to some Federal office for help and we want to be able to tell them where to go.

Dr. BRANDT. Well, if they want to go to a Federal office for treatment of their child who is addicted to drugs, there is no such activity, and never has been, as far as I know.

Mr. RANGEL. They want to go to a Federal office to pick up information. If they want to go to a Federal office for treatment, you don't believe that that should be?

Dr. BRANDT. I think that treatment, medical care in this country has always been handled locally, and it should be handled locally, and——

Mr. RANGEL. Well, if we have programs that would be funded directly by the Federal Government?

Dr. BRANDT. The funds are there now permitting the State of New York and the city of New York to decide their best priorities and to follow up. And we do have an office in New York City to which people can go if they want this information.

Mr. RANGEL. As far as you're concerned, you're proud of the job that the Federal Government is doing in this area. Do you think it's improving and it will get better?

Dr. BRANDT. I think that the job that we are doing is improving and that it will continue to improve, yes.

Mr. RANGEL. Mr. Akaka?

Mr. AKAKA. Thank you very much, Mr. Chairman.

Dr. Davenport——

Dr. DAVENPORT. Yes, sir?

Mr. AKAKA [continuing]. Does the Department of Education think that this problem is so extensive and serious for the future of our country that the Department of Education has established some priority for drug abuse treatment and programs?

Dr. DAVENPORT. We believe that there is a need for the Department of Education to be involved. That's why we have the drug abuse education program which I outlined earlier. This program involves the five regional training centers, and, I should add very quickly, not only train the teachers, but also train the parents to go back to work in their communities. Each team trains another team to work at these problems in their school districts.

Mr. AKAKA. I ask that question as to what priority it was for you because we see that funding is not really commensurate to the importance of the program, and this is a point that we want to look into as you continue your plans.

I also note that you call the team approach, school team approach program, as the backbone of your drug abuse treatment activity. You also have included parents as well as teachers and also have involved some Government agencies in your efforts.

Let me ask you in particular, what funding is presently being given this program?

Dr. DAVENPORT. Approximately $2.8 million this year. As you know, this year we have requested additional funds under chapter 2 for fiscal year 1985.

We believe that decisions about local priorities and the best approaches to meet those priorities can most effectively be made at the local level. We have asked for an increase of over $200 million for our block grant program.

Mr. AKAKA. And, you're spending $2.8 million. How many staff are assigned to this program?

Dr. DAVENPORT. Staffing? Let me provide that for the record, Mr. Chairman.

One person has lead responsibility for the administration of the program and other staff members are available as needed.

Mr. AKAKA. All right. Fine, that will be fine. Do you foresee, because of the importance of the program, any increase in funding for this program based on increased demands for drug education?

Dr. DAVENPORT. We have a proposed increase for next year in the program, I believe it's about $130,000

Mr. RANGEL. How much did you say?

Dr. DAVENPORT. About $130,000.

Mr. RANGEL. $130,000.

Dr. DAVENPORT. Because, Mr. Chairman, we requested an increase of over $200 million in the block grant program that can be used by school districts that find drug abuse education a priority in their communities.

Mr. AKAKA. In your testimony, you've stated in several pages what you have been doing with your school team approach.

Can you explain why the administration has not given the school team approach program more visibility than it has?

Dr. DAVENPORT. We believe that it has been given significant visibility. We have been working with other agencies on various task forces here in Washington, such as HHS, ACTION, and others, who are working in this field, to spread the word even further.

If you talk to various people at the technical assistance centers, I believe they'd be very proud of the job that they've been doing. The same is true of the school systems that have had these teams working in their schools. I believe they would be very pleased with the activities of their teams.

We believe the program has gained prominence. We're looking at ways to work cooperatively with other agencies in Washington to increase its impact.

Mr. AKAKA. My particular interest in this is to know how you regard this program and its importance. I would like to know what you are doing in your activities, where you are putting your money and how you are placing your staffs.

And, I particularly wanted to ask you about staffing because I received word that the school team approach has been reduced from six staff to one, but I'm sure we'll get that in the information that you submit.

Dr. DAVENPORT. Mr. Chairman, the number of staff here in Washington doesn't have a relationship to what we're doing out in the field.

The staff here in Washington was really to facilitate getting the money to the regional centers which actually do the training.

There is no relationship between the number of people we have here in Washington sitting in an office and the import of the program. Our major responsibility is to get the money out to the training centers to allow them to do the actual training, and not to have people here sitting in an office because there was very little for them to do.

Mr. AKAKA. So, you have reduced it from six to one here in Washington?

Dr. DAVENPORT. I don't have the staffing patterns here, but the number of people is irrelevant. The relevant factor is that the same amount of money is going to the training technical assistance centers that are actually doing the job.

Mr. AKAKA. So, you are telling me that you depend a lot on the staffing that's done on the local level to carry out these programs?

Dr. DAVENPORT. We fund five regional training centers that provide the training and technical assistance to the local school districts.

The money is to allow those five training centers to provide the services. They didn't need six people telling them what to do, what they needed was the money to provide the training.

WHAT DOES A TEAM DO? HOW DOES IT OPERATE?

The Alcohol and Drug Abuse Program funds five regional centers which develop problem solving "teams" of educators from each local school participating in the program. The responsibility of each team is, in general, to develop and implement activities that address their school's needs and circumstances with respect to alcohol and drug abuse. The team consists of five to seven persons, and is usually headed by the school principal or an assistant principal. The importance of this fact cannot be overstated. It means that the team is headed by a person with decision-making authority in the school organization. It also means that the program will have the benefit of support from those persons in the school responsible for providing leadership and direction to all aspects of the school's program.

What does the "team" do? First, the team receives training at the regional center. The training provides team members with knowledge and problem solving skills. The training includes such things as up-to-date information about drug and alcohol abuse and introduction of program models; i.e., peers against drug abuse, in-school suspension, new methods of classroom management, in-service teacher training, students against drinking and driving, school alcohol and drug policies, parent involvement against drug abuse.

Program development skills are provided in such areas as conflict resolution, identification of school alcohol and drug abuse problems, counseling, decision-making, communications and problem solving.

From the methods and models presented, the team develops a plan of action that is its own, i.e. a plan of action developed in response to its unique school situation. The team does four important things: first, it shares the knowledge it has received with others in the school community; second, it provides training to other school personnel and community representatives; third, the team serves as an on-going resource for problem solving in the school; and fourth, the team provides support to the entire school as it implements the school's action plan. When a cluster of teams is funded it serves as a problem solving resource for the whole school district.

The latter two tasks of the team are of critical importance. In order for a program to be successful, newly acquired knowledge and skills must be translated into action. The resource activities of the team insure that as a school begins to implement its plan, staff will have someone to go to if they encounter difficulties or have further questions. The regional centers also provide on-site technical assistance to participating schools. Through the data base contract, teams have continuing access to the most current information.

Mr. AKAKA. Now, this also points out another kind of problem that can exist and which does exist, not only with your agency, but with most Federal agencies, and that is the relationship of working with local, State authorities.

How would you assess your relationship with the State and local agencies?

Dr. DAVENPORT. Excellent.

Mr. AKAKA. Does this mean also, when you say excellent, that this has reduced drug abuse in the schools and in the communities that you work with?

Dr. DAVENPORT. I think overall the school districts would say that the team approach has assisted them in dealing with their local problems.

If you are asking the degree to which they have relaxed drug abuse I wouldn't be able to answer that. But, if you are asking

whether they have been successful in the school districts, then evaluations tell us that they have been.

Let me explain the organization to you. We contract with the regional centers which subcontract, with school districts for the organization and training of school teams. These teams include parents, teachers, administrators, and students who devise local solutions for that communities alcohol and drug abuse problems.

Only local public school districts and private schools may apply for assistance underneath the Alcohol and Drug Abuse Education Program.

Elementary schools are not eligible Our focus is on grades 7 through 12. Applications from local school districts and private schools to participate as subcontractors in the Alcohol and Drug Abuse Education Program may be submitted to the Department of Education, regional contractors, the five regional training centers I mentioned earlier.

Mr. AKAKA. I see. As you know, this hearing is being held to make an effort to review our Federal initiatives as you are doing with local and State groups. Also, we are looking at the text of block grant funding and the reason for that is that we hear from the local levels. They, in a sense, complain that they are not receiving enough funds, that they have been cut in funds. I know the answer has been, it's more cost effective, and we want to look into that. We are looking towards the need for increased Federal leadership, and that's why I asked the question about your relationship with local and State governments as well as with Federal agencies.

Now, you point out that you have one person——

Dr. DAVENPORT. No, I didn't.

Mr. AKAKA [continuing]. Here in Washington——

Dr. DAVENPORT. No, Congressman, you did. I said I would provide that for the record.

Mr. AKAKA. Right. I did. That's the word I got, and if it is true, I worry about how one person can attend to the many needs at the State and local level.

Dr. DAVENPORT. That's not their job. There is a misunderstanding about the functions of this office.

No one person has the job of providing leadership. Leadership is provided by the Secretary and the Undersecretary, myself and the chapter 2 program staff and the State and local educational program staff. The position that you're talking about is responsible for facilitating to those five regional centers.

The coordination effort between HHS, ACTION, and the others is a departmental effort. The number of staff people in the Washington program office has no relationship to the impact of the regional centers. This program office makes sure that the contracts are being carried out effectively, it is only one small part of our leadership efforts.

Mr. AKAKA. Well, thank you very much for your time.

Mr. RANGEL. Thank you very much, Mr. Akaka.

Mr. Coughlin?

Mr. COUGHLIN. Thank you very much, Mr. Chairman. I must say that I somewhat disagree with my distinguished colleague and friend, the chairman of the committee.

I do believe that the President, the First Lady and the administration have had a higher visibility in the area of drug abuse and placed a higher priority on the area of drug abuse than any other administration in my knowledge, and I've been here for 16 years. I want to commend him for that.

At the same time, my experience in many hearings before this committee, has led me to believe that drug abuse education, indeed, is a very key part of the whole formula. As long as the demand is there, as long as the money is there, and we can do all the interdiction work we want, there will still be a supply because it's a huge business.

I just want to follow up, if I might, a little bit on the question of drug abuse education. The law presently provides, as you indicate in your testimony, Mr. Davenport, on page 9, that 20 percent of the State funds must be expended on alcohol and drug abuse prevention and education programs.

Do you monitor the nature of those programs from a Federal standpoint?

Dr. BRANDT. I believe that's in my testimony rather than that of the Department of Education. We administer that particular block, Congressman.

We monitor, first, to be sure that they are meeting the criteria of the law. That's a requirement.

We monitor what they are using funds for, in an informal way—largely because of our close work with the National Association of Alcohol and Drug Abuse Directors, State Alcohol Drug Abuse and NASADAD.

We do not try to monitor it on a rigid kind of basis so that we do not know precisely what every school district or every locality is doing. We have some idea of what they are doing largely because much of what they do is based upon materials that we prepare and/or ideas that we have developed. They get that kind of information from us and make use of it. That gives us another source of information about what they are doing.

Mr. COUGHLIN. Do we have any data on how many States require, say, how many hours of drug abuse education per semester?

Dr. BRANDT. No, we don't have any such information.

Mr. COUGHLIN. Does the Department of Education have such information?

Dr. DAVENPORT. No, sir.

Mr. COUGHLIN. Would it be useful if the Congress mandated that the Federal block grant funds were contingent upon the States providing some specific number of hours for drug abuse education per semester?

Dr. BRANDT. I would think, Congressman, that if one uses the broadest definition of drug abuse, then I think it makes sense to try to make sure that this is included. But my own view is that the most effective educational programs are those that make the young people aware of their own concepts of self-worth, and aware of their own ability to promote their good health in all spheres of activity.

What is clearly seen in many of the studies is that if you're not cautious when you decrease the use of pot in high school students, you increase the use of alcohol. Really trading one drug for an-

other. I think it would have to be very, very carefully done because—frankly, it's not something I've thought about directly.

But, I think it would have to be within the total context of trying to get people to recognize the adverse health consequence of drugs, improving their own concept of health as an important part of their being. We would be pleased to try to think this through a little bit more and talk to you about it.

Mr. COUGHLIN. Does either of the Department of HHS or the Department of Education provide to the States a model drug and alcohol abuse program that would be for so many hours a semester, that could be presented to students in the 7 to 12 grades, in particular?

Dr. BRANDT. Well, we have such curricula outlines available now for teachers that wish to use them or schools that wish to use them. There is a publication called "Teaching Tools" that outlines what curricula is available and we certainly could make that more available and more widespread.

Mr. RANGEL. How much does that cost?

Dr. BRANDT. I don't know the answer to that. We will let you know.

Mr. COUGHLIN. Could you provide that for the record?

Dr. BRANDT. Yes. "Teaching Tools for Primary Prevention" is free of charge and available in unlimited copies.

Mr. COUGHLIN. If a school district wanted to install a program of drug and alcohol abuse education for so many hours a semester and applied to you, it would be able to get such a program; is that correct?

Dr. BRANDT. We can give them an outline of such a program, yes, and what it would cost, I'll just have to let you know.

Mr. COUGHLIN. Would that program include teaching materials, movies, slides, posters? What would that——

Dr. BRANDT. It would include educational materials and we have a new drug education module that has recently been developed. It is available through the Centers for Disease Control, so that there is a wide variety of materials available to them.

Mr. COUGHLIN. Do you have a standard program that the Federal Government can say, here is our best effort, here's a 4-hour a semester drug abuse program that we have found effective?

I realize this may be tailored to individual parts of the country, but do we have such a program complete with educational materials?

Dr. BRANDT. We have an outline of such a program which then permits the teachers to choose and to use, depending upon the kinds of students they have and the circumstances under which such education is offered—the materials most suited to their needs. The answer, I think, to your question would be yes, with the modification that we have to allow the individual school some voice in what they teach. That would be the caveat, I suppose.

Mr. COUGHLIN. And, if the Congress should mandate that a part of this 20 percent for drug abuse prevention be used to install that program in every school in the particular State, what would be your reaction to that?

Dr. BRANDT. Well, my reaction to it would be as follows. We are in favor of removing all of the requirements on this block grant be-

cause we are convinced that the current earmarks that are in there do, in fact, hamstring the ability of the States and the local officials to respond to the kinds of problems that they deal with.

It makes it impossible for New York to respond to the backlog that they have for methadone treatment through the use of block grant funds because the amount of block grant funds available for drug abuse are limited by the law.

Our own view would be that we would do better by removing all of the earmarks and letting the States make these options. We can market the kind of information to the States who really want to get into drug education modules and let them use it to meet whatever their basic needs are, to spend those moneys for whatever their basic needs are.

It's clear from the various reports that are pending across the country that total expenditures for drug abuse prevention and treatment, have gone up by some 10 percent from 1980 to 1982 indicating that a lot of people are getting into this, are interested in it, and are trying to do something about it.

Mr. COUGHLIN. But, neither in the Department of Health and Human Services nor the Department of Education do we know how many States mandate how many hours of drug abuse education per semester?

Dr. BRANDT. We do not know that, no, sir. We can look and see whether there's some place in the Department we might have that information, and if so, I'll be happy to supply it. But, I don't know.

Mr. COUGHLIN. How about the Department of Education?

Dr. DAVENPORT. We don't know either, Congressman. We would also have to check to see if there is someone in the Department that might have it.

The information is not available in the U.S. Department of Education or anywhere else to our knowledge on a national basis.

Mr. COUGHLIN. If you have that, could you provide it for the record, and, if not, I would suggest that it would be very useful information to have, to really find out how much drug abuse education we are actually giving to our young people and what the nature of those programs are. I'll yield in just a moment because that comes back to my prime concern that if the demand is there, the supply is going to be there, and if we're not reducing the demand by appropriate drug abuse education and alcohol abuse education of our young people, we're never going to really solve the problem.

Let me yield back, Mr. Chairman.

Mr. RANGEL. Mr. Hall of Texas.

Mr. HALL. Thank you, Mr. Chairman.

You know, listening to the testimony of the three gentlemen at the desk remind me of the firing squad that lined up in a circle. They shot each other.

I'm concerned about what I've heard here this morning. It appears to me that it's a typical bureaucratic mess in trying to administer something that no one really knows what the end result is going to be.

In the last question, for instance, you don't know how much drug abuse education is being supplied to the youth. I don't understand why you don't know that, being head of this area that supplies it.

Second, I'm not too sure that, from the testimony I've heard this morning, that this is getting down to the people that it's suppose to help. Now, we hear a lot about the funds, and we hear a lot about something here in Maryland where you can do certain things, but the thing that impressed me more than anything is someone mentioned earlier about maybe a school or classroom in New York where 20 percent of the—someone correct me if I got this wrong, in that class are drug addicts. Did I hear that properly?

Was that from you, Dr. Davenport?

Dr. DAVENPORT. No, sir.

Dr. BRANDT. Not from me either.

Mr. RANGEL. Well, the Chair said that.

Mr. HALL. Somebody said it.

Mr. RANGEL. Well, if we have two-thirds of the kids that are not using drugs, I assume that one-third are, and this would be the statement given by Dr. Brandt that we should thank God for two-thirds who are not.

Mr. HALL. Well, that doesn't satisfy me, Mr. Chairman, with that answer.

Mr. BRANDT. Let me——

Mr. HALL. Dr. Brandt, let me ask you a question. Suppose what the chairman said is true, and I'm sure that it is, because we've had testimony in New York City about the tragic consequences of schools there, I won't go into it. But where you have a class like that and you say that 20 percent of those people are drug addicts or drug users, I'm assuming that the teacher of that class knows that. Would that be a fair statement?

Dr. BRANDT. I would assume that they would know it, yes.

Mr. HALL. Well, if you assume that the teacher knows that, what program do any of you have that would help those people that are drug addicts?

Dr. BRANDT. Well, there are drug abuse treatment centers that are locally operated by local physicians and by local authorities throughout the country. In fact, they always have been operated by local authorities as are all other medical care programs.

Now, I'm from Texas like you are, sir, and I can tell you, having sat on the board of those programs and having been involved in them, they are everywhere in the country and available. Student drug abusers would be referred by the teacher through the school system to the local drug abuse authorities for treatment.

Mr. HALL. Well, after the teacher refers them to the school people who eventually refer them to the centers, is there any followup to see if that treatment is administered to those people?

Dr. BRANDT. Yes, the local authorities—again, the local people providing the treatment almost always provide followup to try to determine whether or not: (a) the treatment was effective, and (b) whether or not the person continued in the program.

One of the issues has been in the past has been the length of time that was required to accomplish this. In the past it has been dealt with on a basis of 21 to 30 days. Now, we advocate that they

follow them for at least 6 months to try to determine whether or not they are staying off of drugs.

Mr. HALL. Have you determined whether or not that theory is working in actual practice?

Dr. BRANDT. We have evidence through various surveys that, in fact, it does work if the counselors do maintain contact with the people and keep them off of the drugs of abuse.

Mr. HALL. Is that counselor funded by Federal funds?

Dr. BRANDT. They may or may not be. There has always been a wide combination of moneys that have been used in drug abuse programs, and from what source an individual counselor is paid will vary a great deal because they are sometimes paid by fees of the people participating in the program, by local moneys, by State dollars and by Federal dollars, and by insurance—third party payors.

Mr. HALL. Has the Department of Health and Human Services ever conducted a survey on a pilot school or a certain place to determine whether or not what you have just indicated should be done has worked?

Dr. BRANDT. Yes.

Mr. HALL. Where?

Dr. POLLIN. We've conducted and are presently continuing a number of very large-scale treatment outcome studies. They are not specifically focused on a given school or classroom, but they are looking at the treatment effectiveness of a wide variety of all of the treatment modalities currently used, and as Dr. Brandt indicated, they do clearly show that where drug users do remain in a treatment program for any significant period of time, treatment currently available is effective.

Mr. HALL. Have you ever conducted such a survey on one school to see if it works for that one particular area?

Dr. POLLIN. To the best of my knowledge, there has been no study specifically focused on one school. There have been and are continuing studies in individual communities which include a number of schools, but would not be limited just to one school.

Mr. HALL. Well, is it the testimony of each of you gentlemen that there is a need for additional funds over and above what funding you have at this time?

Dr. BRANDT. For the purposes of drug abuse prevention and——

Mr. HALL. Yes.

Dr. BRANDT. Treatment, I think——

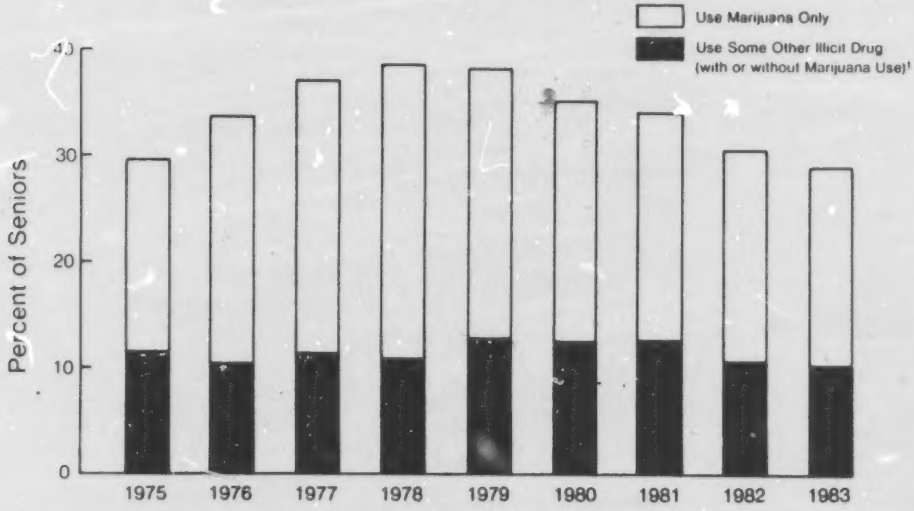
Mr. HALL. Yes.

Dr. BRANDT [continuing]. That with the kind of problem that exists, at the present time, total funding from all sources is probably not adequate to attack the whole problem.

However, it is increasing. Mr. Hall, you also asked us whether or not we knew what we were doing, and why we didn't, and I would like to point out to you some evidence of what is going on, and I'll supply these for the record.

[See charts on pp. 23–27.]

## Prevalence of Past Month Illicit Drug Use by High School Seniors




[1]Includes Any Use of Hallucinogens, Cocaine and Heroin or Any Nonmedical Use of Other Opiates, Sedatives, or Tranquilizers; Marijuana May Have Also Been Used.

Note: Amphetamines Were Executed to Eliminate Trend Artifacts Resulting from the Erroneous Reporting of OTC and "Look Alike" Stimulants as Prescription Amphetamines

Source: NIDA, Monitoring the Future Study, 1983.

55-1

# Past Year Experience with Illicit Drug Use*
## 1982

Household Population 12 and Older

| | Youth 12-17 | Young Adults 18-25 | Adults 26 and Older |
|---|---|---|---|
| Some | 22% | 44% | 12% |
| None | 78 | 56 | 88 |

*Includes Marijuana, Hallucinogens, Cocaine, Heroin or Prescription-type Psychotherapeutic Drugs (Stimulants, Sedatives, Tranquilizers and Analgesics) for Nonmedical Purposes.

Source: NIDA, National Survey on Drug Abuse, 1982.

## Any Lifetime Experience with Illicit Drug Use*
## 1982

Household Population 12 and Older

| | Youth 12-17 | Young Adults 18-25 | Adults 26 and Older |
|---|---|---|---|
| Ever | 28% | 66% | 25% |
| Never | 72 | 34 | 75 |

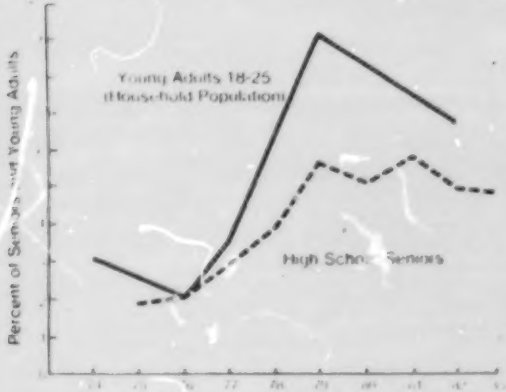
*Includes Marijuana, Hallucinogens, Cocaine, Heroin, or Prescription-type Psychotherapeutic Drugs (Stimulants, Sedatives, Tranquilizers and Analgesics) for Nonmedical Purposes.

Source: NIDA, National Survey on Drug Abuse, 1982.

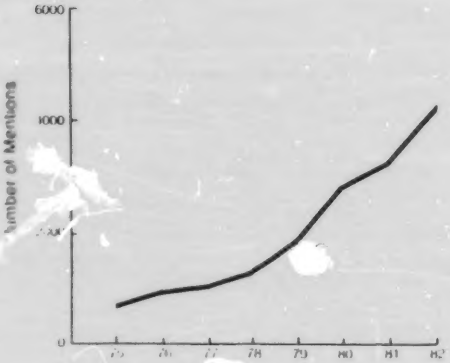
25

55-3

Trends in Prevalence of Current[1] Cocaine Use by High School Seniors and Young Adults 18-25: 1974-1983




Trends in Cocaine Emergency Room Mentions: 1975-1982




Source: NIDA Drug Abuse Warning Network (DAWN) Panel of Hospitals Reporting at Least 6 Months Each Year





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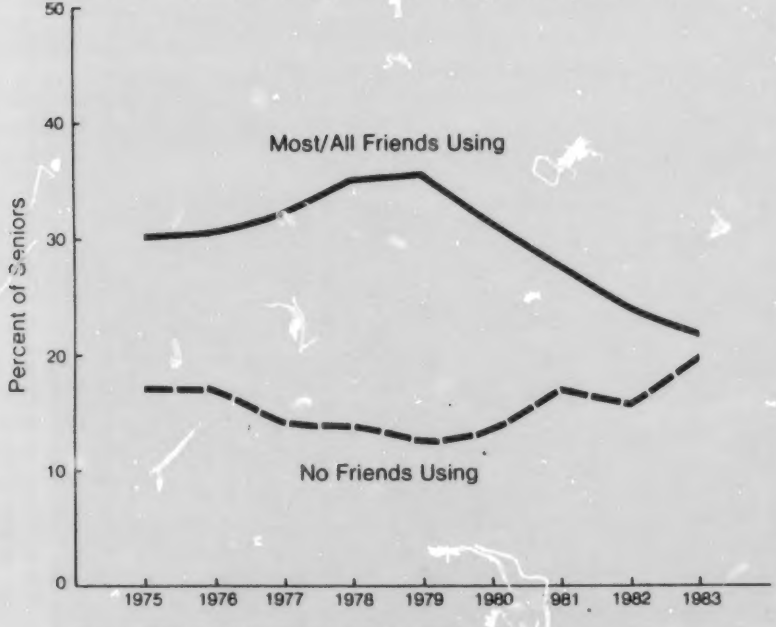
## Trends in Proportions of Friends Using Marijuana as Reported by High School Seniors: 1975-1983




Source: NIDA, Monitoring the Future Study, 1983

27

55-5

There is the prevalence of the use of illicit drugs in high school seniors within the past month. This peaked around 1979. Since 1979, it is steadily decreasing. This is all illicit drugs.

Mr. HALL. Now, is that all drugs?

Dr. BRANDT. Any illicit drug. Marijuana is shown in white and other drugs in black. If you look here at—and we were talking a minute ago, I gave the overall figure of one-third of America. If you look at youth, between the ages of 12 and 17, the past year experience with illicit drug use indicates that 22 percent of them used some drugs.

That does not mean that they are addicted, it does not mean that they are necessarily using it on a daily basis or more frequently. But, rather, that they had some exposure to it. The largest group that had exposure were the young adults between 18 and 25. This is 1982 data. If you look at any lifetime experience with illicit drug use, the youth again, 12 to 17, 28 percent is indicated.

Those figures are all coming down, coming down slower than any of us would like, but they are, nevertheless, coming down. That, it seems to me, is some evidence that the educational programs—and I fully agree with you, that education is the key to this effort—are beginning to work.

Now, you know, if I had my way, that figure would be down to zero, but there are a lot of very, very potent forces operating against us. It's a big profit making business out there, and there are a lot of people in it. I think that the efforts that are being made are beginning to show some promise, beginning to show some results, and I think with some intensification of these efforts, that these trends can continue.

Mr. HALL. Is that your same testimony, Dr. Davenport, essentially in the area that you operate?

Dr. DAVENPORT. Yes, sir. We believe our budget request is adequate for our contribution at this point.

Through our emphasis on private sector initiatives we are moving to involve more people in solving this problem. The same is true of our work with parent groups. We have asked for a modest increase for the program for next year, and we believe that is the appropriate level of funding.

Mr. HALL. When you speak of the private sector, explain to me what you mean by that.

Dr. DAVENPORT. Attempting to get service clubs, corporations and others involved in providing funding or assistance to these programs.

Mr. HALL. Are you being successful in that effort?

Dr. DAVENPORT. There has been some success in this effort. Some of the things Peoples Drug Stores is doing with HHS along with several other initiatives are successful.

Mr. HALL. I yield back the balance of time.

Mr. RANGEL. Mr. Shaw of Florida.

Mr. SHAW. I have no questions, Mr. Chairman.

Mr. RANGEL. Well, I just want to have the record clear that any statement I made that implied that the First Lady was not visible in connection with her concern about drug abuse was not intended, even though the questions of priorities of the administration in

terms of education prevention is an on-going effort by this committee.

It's a little difficult for me to understand how you reached the statistic of the decline, and maybe that's because of the area that I represent as it relates to drug addiction and things that Dr. Pollin has emphasized that in the minority communities, there is a sharper increase in abuse of all drugs.

By the same token, it would seem to me that if other communities had the same type of dropout rate and unemployment rate as I find in some parts of my district, it would be very difficult for you to accumulate the type of data that you have in terms of showing a decline.

And, with the materials that are available that you were talking to Mr. Coughlin about, those materials are for sale, aren't they?

Dr. BRANDT. The——

Mr. RANGEL. You've stopped all of this——

Dr. BRANDT. Oh, no, no, no, no, no. We make a lot of information available, but the implementation of it may, in fact, cost money and I'll have to supply you the specifics with respect to that.

Mr. RANGEL. I'm talking about the publications, it's my understanding that in May 1983 these materials were available one to each person, and that when you want them for school classes, that you have to purchase them rather than receive them free as in the past.

Dr. BRANDT. Well, there may be some for which that's true. But for many of these pamphlets I have here and for others, that's not true.

Mr. RANGEL. That's not the Peoples' pamphlet that you have there?

Dr. BRANDT. No, sir, that's not.

Mr. RANGEL. But, educational materials are provided free for classroom use?

Dr. BRANDT. Some—yes, it depends a little bit upon what educational materials you're talking about, but many of them are free.

Mr. RANGEL. Anything that are tools for the teachers——

Dr. BRANDT. Some are free and some are not, and, yes, sir.

Mr. RANGEL. This school team that you talk about, what is a school team, Dr. Davenport?

Dr. DAVENPORT. It's made up of faculty administrators and——

Mr. RANGEL. I mean, what area would it cover and what number of people are involved?

Dr. DAVENPORT. There were 140—in 1983, there will be 140——

Mr. RANGEL. Let me try it again. You said the Federal investment for each school team, you're not saying that each public school has a team that's funded for $20,000?

Dr. DAVENPORT. Each team that we fund costs about $20,000. Districts they can also use their chapter 2 funds if they want, but this figure represents what we fund under the alcohol and drug abuse program.

In fiscal year 1983, 135 teams were funded at a total cost of $153,170. This is an average cost of $4,245 per team.

Mr. RANGEL. But, are you familiar at all with how New York City is set up, with its school districts and——



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Dr. DAVENPORT. Yes sir.

Mr. RANGEL. Well, how many teams would you have this year in the city of New York?

Dr. DAVENPORT. I'd have to provide that for the record. I don't know.

No New York City schools applied for funding in fiscal year 1984. One New York City Community School District has applied for funding this year—fiscal year 1985.

Mr. RANGEL. Just a gamble, you know. It's the capital drug abusing city of the world. So——

Dr. DAVENPORT. I would hope to provide it for the record. I'm just not aware of the——

Mr. RANGEL. Chicago? How about the District of Columbia, how many teams would you have in the District of Columbia?

Dr. DAVENPORT. I didn't bring specific information on each place there is a team, but I would be able to provide that for the record.

No teams from the District of Columbia have applied for funding.

Mr. RANGEL. Where do you have your team concentrated?

Dr. DAVENPORT. I don't have that with me.

Mr. RANGEL. How many teams do you have?

Dr. DAVENPORT. 140 new teams this year.

Mr. RANGEL. How many old teams?

Dr. DAVENPORT. A total of 4,500 teams have been trained.

Mr. RANGEL. And, since the administration, you mean, in the last three and a half years?

Dr. DAVENPORT. No; since the program was initiated.

Mr. RANGEL. What year would that be?

Dr. DAVENPORT. 1972.

Mr. RANGEL. Well, we don't want to go back that far to find out where those teams are, but how many active teams are being trained now?

Dr. DAVENPORT. 140 for 1983.

Mr. RANGEL. And, you would not know what communities these teams come from?

Dr. DAVENPORT. We do know, I just did not bring that information with me.

[See app. A, p. 154.]

Mr. RANGEL. Well, I gather there's a sharp difference as to what the Federal commitment should be and I think, Dr. Brandt, you made it abundantly clear that Federal presence is support and outreach of the private sector help, I think, all three of you agree that that is your position.

But, I think it's sad to see communities being exposed to increasing addiction problems where the Federal statistics prove that and to find that parents have to call for help or rely on teams, not knowing whether there is a team in their community, and there's a philosophical difference, I believe, as to whether or not the Federal Government—we talk about law enforcement, education or rehabilitation, should be able to say that we're there, we're on the front line and we know what we're doing and we're evaluating whether it's working and whether it's not working.

This approach in allowing the local communities to determine the priorities should rely in a large degree as to what city councils and State legislators are prepared to do. Since the facts cannot be

disputed, that 85 percent of the marijuana is imported to the country, all of the cocaine, all of the heroin is imported, for you to sit there and say it's a local and State problem is consistent with the administration's view.

But, I seriously differ with you. It's poison. It's coming into the United States. It's coming from foreign countries. It just appears to me to be an international drug trafficking problem, and that the very least, it has to be called the national problem rather than allowing local governments to decide what they are going to do. There's no relationship at all with the Federal dollar that's dispensed in connection with the number of people that are adversely affected.

There's no relationship between the money given and the money that local and State governments are putting up to try to resolve this problem, and I suspect that there is nothing we can do to change you philosophically, and I guess we'll do the best we can, and I want to thank you for taking time out to share with us——

Mr. SHAW. Mr. Chairman, a question came to mind while you——

Mr. RANGEL. Sure, sure.

Mr. SHAW [continuing]. Were discussing this with the panel Do we have any statistics as to the direct impact the use of drugs has had as for dollars spent?

Now, what I'm speaking of, Dr. Brandt, you held up a chart to show that the use was declining and, therefore, that the educational process must be working. Well, there could be some other factors out there that are working.

Have we looked at a local community, a local school board, a local program, and been able to say that education really is the key, or have we funneled higher amounts of Federal money into a particular area and monitored the programs to be sure that they are being used usefully so that we can say that education is the key?

What do we know about the dollars spent on education and the results?

Dr. POLLIN. We currently have an evaluation project underway, Mr. Shaw, trying specifically to disentangle the impact of different components in our prevention and education programs.

The one now underway focuses on trying to measure the specific impact of some of our major media campaigns, and once we have that nailed down, then we hope to go on to other of the major elements which include education. One of the factors we haven't emphasized here this morning that we think is very important, is the development of the grassroots movement expressed in the parents groups that have sprung up around the country. These now number over 4,000. We think they have played a major contributing role in changing the upward trend of drug use and beginning to bring it down.

Mr. SHAW. You've answered my question by saying something—by giving an example that didn't require the use of Federal funds other than media advertising.

Have we done that before?

Dr. BRANDT. Well, the media advertising is Federal funding.

Mr. SHAW. Obviously, parent involvement is crucial to this, and probably more important than anything we can do or that State and local government can do.

Dr. BRANDT. Yes.

Mr. SHAW. The question I have is, what are we getting for our dollars spent on education, the direct educational programs rather than just putting on a blitz of sports figures or someone getting up and saying drugs are bad?

Dr. BRANDT. I don't think that we have the kind of information that you're asking for with the kind of precision you are requesting, although we will certainly look and try to find out.

But, I do think you've made a very important point, Mr. Shaw. That is, that in this kind of thing—as in dealing with any other kind of health issue—it is very complex. To say that because we put on so many hours of instruction in schools has resulted in a decreased drug problem, it seems to me, would totally eliminate the role of parents, would totally eliminate the role of the mass media in trying to set up role models and other kinds of things.

So, it is a complex issue—we have to be cautious with complicated problems like this, not jump to simplistic solutions—and I think we will go back and see what kinds of information we have available to answer specifically the questions that you've asked, although I doubt that we have it with very much precision.

Mr. SHAW. I think when we're talking about the millions of dollars that are being spent and perhaps the billions that are actually required on a combination of State and local basis, I think those are the kinds—that's the type of raw data that we need here in the Congress to make intelligent decisions.

You know, we're often accused, and I think rightfully so, of throwing money at problems, but we depend very heavily on witnesses such as you to tell us what's working and what's not working. Without that information, we cannot make intelligent decisions about funneling those dollars in the right places.

So, I would hope that that information would be forthcoming, and forthcoming as quickly as is possible. What is working? Why are those figures going down? And, Dr. Brandt, I think the conclusion that they are going down and then, to say we can't jump at simplistic conclusions, well, we need to come up with something and we have to know what we are doing, and whether it's correct and whether we're getting our money's worth.

Dr. BRANDT. In April of this year, we supplied a report to the Congress on prevention activities of the entire alcohol, drug abuse, and mental health administration. I have a copy of it here, and we include in there the evidence that we have of the success, of the effectiveness of various educational programs. That begins on page 39, and I think that we will try to summarize that in some more detail, and to provide that to you so that you will have the kind of information that you're requesting.

### EDUCATIONAL APPROACHES TO PREVENTION

#### INFORMATION DISSEMINATION

Until recently efforts to prevent substance abuse generally involved the presentation of factual information. Tobacco, alcohol, and drug education programs were

based largely on the assumption that increased knowledge about these substances and the consequences of their use would be an effective deterrent. These programs primarily attempted to increase students' knowledge about the legal, pharmacological, and medical aspects of using these substances.

#### AFFECTIVE EDUCATION

These programs are categorized as "humanistic" or "affective" education programs, and generally attempt to enrich the personal and social development of students. The focus of these prevention programs has been to increase self-understanding and acceptance through activities such as values clarification and decisionmaking; to improve interpersonal relations through activities such as communication training, peer counseling, and assertiveness training; and to increase students' abilities to meet their needs through social institutions.

#### EFFECTIVENESS OF EDUCATIONAL APPROACHES

Evaluations of programs whose main strategy was providing factual information clearly indicate that increased knowledge has virtually no impact on substance use or on intentions to smoke, drink, or use drugs. Although some studies that contain cognitive and affective components have produced at least some positive results, in general, the "affective" or "humanistic" educational approaches appear to have placed too little emphasis on the acquisition of the kind of skill necessary to increase personal and social competence and enable students to cope with various interpersonal and interapersonal pressures to begin using tabacco, alcohol, and drugs.

### PSYCHOSOCIAL APPROACHES TO PREVENTION

Most recent advances have been prevention approaches that combine a strong theoretical foundation with an emphasis or rigorous research design and evaluation.

#### THEORETICAL FOUNDATIONS

Both social learning theory and problem behavior theory provide a useful conceptual framework for understanding the etiology of substance use. From this perspective, substance use is conceptualized as a socially learned, purposive, and functional behavior, resulting from the interplay of diverse social and personal factors. Differential susceptibility to social influence appears to be mediated by personality, with individuals who have low self-esteem, self-confidence, and autonomy being more likely to succumb to these influences. To be effective prevention programs must deal successfully with potential motivations to use drugs, and must provide students with the necessary skills to resist pro-use social pressure.

Some approaches place primary emphasis on increasing students' awareness of prosubstance-use social pressures (referred to as psychological inoculation) and on teaching specific techniques for resisting such pressures; others emphasize the development of more general coping skills and, from a broader perspective, focus on the most significant underlying determinants of tobacco, alcohol, and drug use through personal and social skills training.

#### EFFECTIVENESS OF PSYCHOSOCIAL APPROACHES

The growing body of research on the recently developed psychosocial prevention programs indicates that both the psychological inoculation/pressure-resistance strategies and the broader personal and social skills training strategies reduce substance use behavior among junior high school students. Both prevention strategies have demonstrated that they are capable of reducing cigarette smoking by approximately 50 percent over a 1-year period. Similar reductions have also been reported for alcohol and marijuana use.

Followup studies conducted for cigarette smoking indicate that the positive behavioral effects of these prevention approaches are evident for up to two years after the conclusion of these programs. Since, for the most part studies testing the application of these prevention strategies to other substances, such as alcohol and marijuana, have only recently begun, followup data for these substances are not yet available. Changes in general interpersonal skills and skills related directly to substance abuse prevention have also been reported as a result of these prevention programs, as have changes on one or more cognitive, attitudinal, or personality-predisposing variables.

Source: Draft Triennial Report to Congress; Drug Abuse and Drug Abuse Research—FY 1984 (In preparation for submission to Congress)

In the interim, I would like to make available to each of the members of the select committee, if agreeable to the chairman, a copy of this total report.

Mr. SHAW. Mr. Chairman, I would just say, and then I will yield back to you and I appreciate your giving me these moments out of turn, that these kids today are bright enough, but they are also adventuresome.

They need to be hit with the hard facts. You know, we get into sex education and we teach them that they can get pregnant. Well, when we're talking about things such as drugs, we have to teach them that they can be killed. That they can end up as junkies and dependent upon these drugs that can absolutely obliterate their entire future.

This is the type of hard facts that I think we need to be telling our young people today, rather than spending a lot of time with glossy type of ads that really don't do anything except perhaps convey some soft message at an early stage.

These are the type of things that I think we have to be thinking about, worrying about and distributing to the young people.

I yield back. Thank you, Mr. Chairman.

Mr. RANGEL. Thank you, Mr. Shaw.

Dr. POLLIN. Mr. Shaw—Mr. Chairman, might I just comment on Mr. Shaw's important observation?

We agree entirely. I would like to reemphasize that since 1978, the percentage of high school students who believe that there is a significant health risk associated with the use of marijuana, and I'm using that just as one example, has doubled. We think that that is an indication of the fact that the very point you're concerned about has, indeed, been dealt with and is being dealt with rather successfully.

Mr. RANGEL. Dr. Brandt, isn't one of the problems with the block grant that you really don't mind what the States do as relates to drug related activities?

Dr. BRANDT. Well, we certainly monitor their expenditures, and we make sure that it's in keeping with the law and so forth.

Mr. RANGEL. I know. But, you don't monitor whether or not——

Dr. BRANDT. We do not try to keep track of how many people are served by the programs and so forth, no. That is correct.

Mr. RANGEL. So, you would not know really whether one State's program is more effective than another in order to——

Dr. BRANDT. Well, the——

Mr. RANGEL. You don't know the number of people involved here and how much it costs per capita.

Dr. BRANDT. Well, we know the people involved, and, in fact, that kind of information is widely shared by those people as it has been for years, and years, and years. I mean, this——

Mr. RANGEL. But, not because you monitor it, I mean, some of these programs haven't been monitored at all by this administration, haven't been visited since they have gotten their money. Isn't that so?

Dr. BRANDT. You know—yes, sir—I have been in this business for roughly 25 years, and watched the Federal Government's so-called monitoring of this program, and the information——

Mr. RANGEL. That would be a terrible thing to do. Listen, maybe it's a bad word and I used it. I apologize. All I'm saying is that it appears to be no accountability to the Federal Government and, therefore, to the Congress as to what they are doing with the money.

You may say, and I just differ with you, that it's none of our business, you know, they pay the taxes, we give them the money, let the local and State officials monitor or determine the way it should be spent.

It's just that as Mr. Shaw said, we like to get excited about things that work. We like to say that there should be more funds for this. We like to cut off programs where we think there is fraud, waste, and abuse, and unless you have monitoring, which may cost more than the program itself, we have no way of knowing and you don't have any way of sharing with us, and we don't even find a relationship between the state effort and the Federal effort because you don't require it.

Dr. BRANDT. I think, though, that what you will find, Mr. Chairman—the point I was trying to make awhile ago—is that this information is shared among the people who are doing the work, independently of any sort of monitoring system that is set up.

That is, the school systems that have effective programs make that information widely known through professional literature——

Mr. RANGEL. I've never heard a school or any other person having a program saying they've got a bad program. But, it's like a Congressman saying he's got a bad record.

But, listen, I can't argue with you.

Mr. SHAW. Mr. Chairman?

Mr. RANGEL. Yes

Mr. SHAW. I think you're making an awfully important point here, and I hope that these gentlemen will take it back with them, and that is the question, we have a lot of people out there, a lot of well meaning people, that are reinventing the wheel and we're coming up with a lot of square wheels that don't work.

We've got 50 States plus other agencies that receive direct funding from us. We, the Congress, quite frankly, are the only umbrella that is really there in place that can really look at the whole field.

And, I think when we send the money down, we do have a responsibility for accountability, and I think that responsibility comes right back here to the Congress.

We have to know what's working, and there's no sense in everyone out there doing something different. Even though I'm a great advocate of block grant funds, I think in this instance, perhaps we ought to be a little more restrictive.

When we send money down for the Federal highway program, there's accountability back to the Federal Government. I think we should expect no less in the drug programs than we do when we're talking about the Nation's highways because we're talking about the future of this country, the Nation's youth.

Mr. RANGEL. Be kind enough to send me the resources that are available in the city of New York, and you won't have to worry about me giving visibility to your program.

Thank you very much for appearing here and sharing your information with us.

Dr. DAVENPORT. Thank you, Mr. Chairman.

Mr. RANGEL. The methadone maintenance programs have been the subject of a lot of controversy, and we have a panel of experts here, Dr. Daniel Michels, who is the Director of the Office of Compliance, Center for Drugs and Biologics, Food and Drug Administration, Department of Health and Human Services, and he'll have with him, Dr. James Cooper, Director of the Division of Medical and Professional Affairs of the National Institute on Drug Abuse, Department of Health and Human Services, and from New York, Beth Israel Medical Center, the general director, Dr. Robert Newman.

As you gentlemen know, there have been any number of reports indicating that there has been a great deal of methadone use abuse and that there has been an increasing number of people dying from methadone abuse with other drugs, and it seems as though emergency rooms in our larger cities are getting increasing reports of methadone related deaths.

We are very interested in your testimony along those lines, and perhaps we'll start with Mr. Daniel Michels.

**TESTIMONY OF DANIEL MICHELS, DIRECTOR, OFFICE OF COMPLIANCE, CENTER FOR DRUGS AND BIOLOGICS, FOOD AND DRUG ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DR. JAMES R. COOPER, DIRECTOR, DIVISION OF MEDICAL AND PROFESSIONAL AFFAIRS, NATIONAL INSTITUTE ON DRUG ABUSE, DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. MICHELS. Thank you, Mr. Chairman. I appreciate the opportunity to appear before the select committee to discuss FDA's role in the regulation of the use of methadone in the treatment of persons addicted to narcotics.

As you know, the FDA and NIDA jointly regulate narcotic treatment programs using methadone, and Dr. Cooper is here to answer any specific questions you may have relative to medical treatment issues.

I'd like to begin my testimony with a brief history of the involvement of the Department of Health and Human Services and FDA in this area.

In 1970, Congress enacted the Comprehensive Drug Abuse Prevention and Control Act. The act's effect on FDA was twofold.

First, it authorized the then Department of Health, Education, and Welfare [HEW], to increase its efforts in the rehabilitation, prevention, and treatment of drug abuse.

And, second, it required the Secretary of HEW to establish medical standards for the treatment of narcotic addicts.

Subsequently, FDA approved methadone on the basis of a well controlled, scientific investigation, as a safe and effective drug for

the treatment of narcotic addiction. FDA had already approved methadone in 1947 for use as an analgesic.

As a result of this approval, FDA began to authorize the establishment of methadone treatment programs. In 1972, FDA published regulations that contained procedures for approval by FDA of treatment programs, mandated standards and established procedures for revoking approval for failure to comply with those standards.

In 1974, in response to the need for clearer Federal authority and control in the regulations for the treatment of narcotic addicts, Congress enacted the Narcotic Addict Treatment Act [NATA]. FDA's primary authority to regulate methadone treatment programs arises under that act. The NATA provides HHS the authority to establish standards for practitioners who use narcotic drugs for either maintenance or detoxification treatment of persons dependent upon narcotic drugs.

In enforcing the act, FDA determines whether a particular applicant is qualified under the standards called for in the NATA to engage in maintenance or detoxification treatment. FDA also determines whether the applicant complies with the standards we and NIDA have established by regulation regarding the operation of methadone treatment programs. Furthermore, the review of initial applications is conducted by the several States and by FDA concurrently. Thus, while FDA gives final approval for a narcotic treatment program, it is contingent upon prior State approval. The act requires that practitioners must not only comply with HHS requirements, but also must be registered with the Attorney General through the Drug Enforcement Administration [DEA].

Largely as a result of the NATA and our desire to improve the operation of treatment programs, FDA and NIDA revised the methadone regulations in 1980. We designed the revisions to allow practitioners greater flexibility in using methadone to treat persons addicted to narcotics. We also revised the regulations in an effort to increase the effectiveness of methadone treatment, reduce the likelihood of diversion by patients, and establish less confusing treatment standards.

FDA's basic role in the regulations for the treatment of addicts with methadone is to review and act upon applications for new or relocating treatment programs. Before approving any program, FDA receives assurance from the DEA and State authorities that the program complies with other Federal and State requirements.

At this time, there are approximately 600 approved narcotic treatment programs in 41 States and three territories. FDA has also approved 200 hospital in-patient detoxification treatment programs.

In an effort to ensure that the narcotic treatment programs are properly administered, FDA also conducts onsite inspections of programs to ensure compliance with applicable statutory and regulatory requirements. These inspections are routine, and we inspect approximately one-fourth of the total number of programs each year. For example, this year, we plan to complete 130 onsite inspections. We do not routinely inspect hospitals that provide inpatient detoxification treatment. We will inspect these institutions, however, if we become aware of a problem or receive a specific complaint.

Administrators of treatment programs are required to submit to FDA annual reports containing information on the amount of methadone used for treatment in a given year, the number of patients in the treatment, the number of new patients entering treatment, dosage levels for clients in maintenance treatment, and the number of patients who receive take-home medication. Much of this information FDA shares with DEA for that agency's use in establishing production quotas for methadone and for assessing whether illicit diversion of methadone is taking place. FDA also reviews and thoroughly evaluates reports of adverse reactions arising in patients receiving methadone, alone or in combination with other substances.

As I mentioned earlier, FDA in cooperation with NIDA, monitors the narcotic treatment standards under which the methadone programs operate. On September 13, 1983, FDA and NIDA published a notice of intent and request for comments on whether changes in the current standards are needed. Specifically, the agencies requested comments on whether the methadone regulations should be more flexible to accommodate changes in medical practice, and whether the regulations should be revised to eliminate recordkeeping, reporting and other requirements that, because of changes in the state-of-the-art treatment, may be unnecessary or overly burdensome. Our initial review of the comments that we have received on that notice of intent reveals a general satisfaction with the regulations and standards.

To summarize, FDA's role involves the approval and clearance of specific methadone clinics, the monitoring of those clinics to ensure that they comply with our regulations and standards, the collection and evaluation of annual reports, the monitoring and updating of applicable standards as necessary, and the evaluation of adverse reaction data concerning the use of methadone.

In your letter of invitation, Mr. Chairman, you asked that we discuss a number of charges which were made against the program last year in a series of articles in the Fort Lauderdale News and Sun Sentinel alleging mismanagement of the program and laxity of oversight or the part of FDA.

I will now discuss the four most significant of these allegations in detail. I will, however, be glad to address any of the other charges or issues which were raised in the articles.

The first allegation was that FDA has failed to collect analyze, and act on drug experience reports for treatment programs using methadone.

This contention is not true. We collect and analyze methadone drug experience reports promptly. Specialized medical officers review these reports to determine the extent and severity of any possible problem. For example, since the beginning of the methadone program, approximately 300 reports per year have been entered into our adverse reaction reporting system, and have been reviewed and analyzed. Depending upon the seriousness of the reactions described in the report, we conduct our own investigation and research into the likely causes of the observed adverse effects. Our investigation may, and on occasion has, resulted in onsite followup and inspection. We have established regular procedures for con-

ducting the investigation and for determining the magnitude of a suspected safety issue.

The second allegation was that methadone is responsible for the deaths of thousands of people.

We strongly disagree with this allegation. Although many adverse reaction reports refer to patients who have died while on methadone, the reports do not provide any substantiation that the deaths were caused by methadone. Rather, the reported deaths appear to arise from the risk factors inherent in the population treated rather than from the use of methadone. For example, many of the reports involve persons with significant mental illness that results in suicide, homicide, or other violent forms of death. Other reports describe exposure resulting from inadequate clothing or shelter as the cause of death. In short, the causes of deaths in these reports vary, and range from no causal association to methadone use for purposeful overdose. In the latter instance, the reports describe methadone frequently as one of several drugs used in the overdose. Only rarely do we see reports where the overdose has been unintentional or involves the accidental ingestion by a person not in treatment.

The third allegation: An example of FDA's lack of concern regarding the operation of methadone treatment programs is the Agency's reduction of its monitoring programs for compliance with statutory and regulatory requirements.

We believe that this statement has no basis in fact. We inspect narcotic treatment programs regularly to assess compliance with applicable regulatory requirements. Although the actual number of onsite inspections has decreased in recent years, the level of regulatory oversight has not. As I mentioned earlier, we are planning to conduct 130 inspections this year. In addition to FDA inspections and reviews, other Federal agencies, such as DEA, and the individual States regularly monitor treatment programs. For example, States in which large numbers of treatment programs are located, such as Michigan with 25 programs, California with 77 programs, and Ohio with 11 programs, annually inspect each program within their jurisdiction. These States also conduct necessary followup inspections to correct deficiencies—eight in Michigan and nine in California, for example. DEA and the States keep us updated on any significant problems discovered in their investigations.

The fourth allegation: FDA has relaxed its regulations concerning treatment programs.

Let me assure you that the FDA has not relaxed its regulations. As I stated earlier, on September 19, 1980, the FDA and NIDA jointly published in the Federal Register the revisions to the Narcotic Treatment Standards which became effective November 18, 1980. In light of the NATA, we revised the regulations to make the clinical standards more applicable to a variety of program settings. We also revised some of the performance standards to make them more clear and specific.

In general, the revised regulations have served the interests of patients and the public quite well. They have not hindered the delivery of medical care to patients, yet they have helped to safeguard against illicit diversion of methadone. Although we made the regulations more flexible, we also strengthened them in many re-

spects. For example, the regulations now contain requirements for developing individualized treatment plans, for assessing patients' responsibilities for handling take-home medication, and for delineating specific requirements for the medical director and the program physician. The current regulations, thus, strike a necessary balance between the risks of diversion and the benefits of enhancing a patient's progress toward rehabilitation, and we believe that these revisions have resulted in increased quality care.

Mr. Chairman, this concludes my statement. Dr. Cooper and I will be pleased to respond to any questions you have.

[Prepared statement of Mr. Michels appears on p. 98.]

Mr. RANGEL. Do the other witnesses wish to supplement your statements? Dr. Newman?

Dr. NEWMAN. If I may, Congressman. I'm very privileged to be here this morning, and I have submitted a statement which I would ask to have included in the record.

Mr. RANGEL. Without objection.

## TESTIMONY OF DR. ROBERT G. NEWMAN, GENERAL DIRECTOR, BETH ISRAEL MEDICAL CENTER, NEW YORK, NY

Dr. NEWMAN. Thank you.

I would like to limit my own testimony, rather than to reread my statement, to what I view as the key issue that really confronts us, not only in New York City, but throughout the country.

There has been an endless debate over issues such as the optimal dosage of methadone, the optimal duration of treatment, and endless discussion, and myriad regulations, concerning staffing patterns at clinics.

I would point out that this type of concern with the specifics of medical treatment is simply unheard of in any other field of medical care. Nobody has ever debated the optimal dosage of penicillin. Nobody knows or even cares what the optimal dosage is of antabuse, which has played a key role in the management of alcoholism.

Even with regard to potentially dangerous, potentially abusable, potentially addicting drugs, such as phenobarbital, which has a use in a wide variety of illnesses, nobody has ever suggested that optimal dosages should be the focus of public discussion and debate. But, in the case of methadone, it most certainly is.

The same with regard to duration of treatment. With regard to a very similar type of problem, namely alcoholism, no one to my knowledge has ever seriously challenged the position of Alcoholics Anonymous, which is certainly the most influential voice in the field, that alcoholism is not a problem of which one can pronounce somebody cured even after many months or years of treatment and care.

Mr. RANGEL. I have a lot of learning to do in this area.

Are you suggesting that methadone is the same as a drink of alcohol or other drugs?

Dr. NEWMAN. Absolutely not. I'm suggesting, Congressman, that the problem of addiction, narcotic addiction in particular, may very well be analogous to the problem of alcoholism——

Mr. RANGEL. But, we're talking about not narcotic addiction, we're talking about methadone addiction. Isn't it an addictive drug?

Dr. NEWMAN. It's a medication which certainly does produce physical dependence.

Mr. RANGEL. Please don't do that, too. You know I don't know what you're talking about.

Dr. NEWMAN. Sure. What it means——

Mr. RANGEL. Is methadone an addictive drug, if you use it till you become dependent on its usage?

Dr. NEWMAN. Yes, if you use it, you become dependent.

Mr. RANGEL. And you can become addictive to it without abusing it, right?

Dr. NEWMAN. Theoretically, one can. In practice, it happens exceedingly rarely.

Mr. RANGEL. But, it's not like going to a bar, is it?

Dr. NEWMAN. The problem of addiction is very definitely, in my estimation, very similar to the problem——

Mr. RANGEL. Methadone is——

Dr. NEWMAN. No, narcotic addiction, heroin——

Mr. RANGEL. Sir, we are here, we know the problems, sir, of narcotic addiction. Now we're trying to find out whether the solution, as relates to the modality of methadone, is almost as bad as the problem. That's what we're here for, and you're objecting, and probably right, that we're scrutinizing the use of methadone.

And, I think what you were saying before I rudely interrupted is that we don't do this with alcohol, we don't do this with other drugs, and so we shouldn't do it with methadone, and I am saying that I have been under the impression that methadone is far more dangerous, far more addictive, and did require far more scrutiny than the use of alcohol.

Dr. NEWMAN. Sure. With regard to alcohol, of course, but there are a great many medications, Congressman, a great many—they number probably in the hundreds—that are every bit as dangerous, that are every bit as abusable, but that, nevertheless, are recognized as having a key role in the medical armamentarium, and that are not subjected to the type of scrutiny that methadone is.

Mr. RANGEL. But, they are not federally funded and dispensed by the Federal Government, Dr. Newman.

Dr. NEWMAN. Yes they are, Congressman. In fact, most medical treatments for a large segment of our population, the elderly, the poor, are supported very, very directly by the Federal Government and to some extent, by the State governments.

I might, if I may, just point out that I think the real issue is not so much a question of the specifics of how a methadone treatment program should be run. The real issue is why we tolerate, as a Nation, a situation where tens of thousands of heroin addicts—people on the streets, shooting up three, four, five times a day, with a very dangerous, potentially lethal drug, which they purchase overwhelmingly as a result of criminal activities committed against the general society—tens of thousands of these people who are not forced by the courts or the police, but who spontaneously want treatment and who come and seek treatment are turned away and told to wait weeks or months before they can be accepted.

The numbers are so staggering that I really think it does a disservice to focus on thousands or tens of thousands. I think it's much more significant to talk in terms of individuals.

Last winter, Congressman, I had the honor of being invited to a meeting in your office in New York City. It had to do with the Manhattan Psychiatric Center, which I serve as a member of the board of visitors. I got up there about 45 minutes earlier than the meeting was to begin. I used the time to visit one of the clinics that Beth Israel operates directly across the street from the Federal Building on 125th Street.

As I recall, it was an extraordinarily bitter morning. It was either zero degrees Fahrenheit, or 10 below Fahrenheit, but it certainly was extraordinarily cold. During my visit there, a young fellow came in with a light windbreaker, and told the receptionist that he was there to seek treatment.

I was there while he gave his history. He had been using heroin continually for a period of 4 or 5 years, interrupted only by a number of arrests and incarcerations. He had had an overdose that nearly killed him the week before. He said he was using about $150 a day worth of heroin. He was supporting the habit exclusively by criminal activities and he was tired of the hassle, tired of the running, and he wanted to be admitted to treatment.

And, while I was there, this fellow joined the ranks of some 1,500 people, that you yourself referred to earlier, Congressman, who are placed on the waiting list.

This man was sent back to the streets. It happens as such a matter of course, in every single program in New York City, that nobody even thought twice about it. Even the addict applicant just accepted it as a matter of course because the addicts of our city know even better than we administrators what the waiting periods are, and what the problems are in gaining admission to treatment.

There is no question that that fellow, when he walked back out on the streets, having left his name on the waiting list, within a matter of minutes, ripped off the next victim. I think that's criminal, Congressman. I think that's absolutely insane from society's standpoint.

When I say criminal, I obviously mean it figuratively. But the fact is in our State, if that same fellow had walked into my emergency room with any other illness, including just a common cold, and had not been treated, had not been seen and treated by my staff, according to the laws of New York that would be a criminal problem for the hospital and for the staff.

The people who seek help for their narcotic addiction have a problem that three or four or five times a day subjects them to a whole host of medical problems, including death from overdose. And you know and I know and everyone knows the plague on society that's associated with it. But only in this particular situation are programs forbidden by the regulatory system from accepting all those who come in.

I feel the question that this committee and that other committees like it have to ask is: "Can every single person who wants and needs treatment for addiction get it at once?" You referred to a constituent who might call your office in New York to ask where a son who's an addict can go for treatment.

Until and unless you, and every other Representative, can have an answer as to where treatment is available immediately, I feel that you're asking the wrong questions. We're debating the wrong issues. It's going to be the continued shame and the pain of our society until we can say, "Of course there's treatment available." Then, hopefully, we can also devote some of our educational activities on encouraging additional people to come in off the streets.

At the moment, nobody could have any kind of a campaign trying to drum up business for addiction treatment. No one could have any public service announcements or posters saying that if you're addicted, come forward, seek help and get rid of this enslavement. There simply is no treatment available. One doesn't advertise what one doesn't have.

I think that is unconscionable. I think it's irresponsible of all of us—physicians, administrators, legislators.

We have got to be able to make treatment available immediately to everybody who wants it and everybody who needs it. Then we can worry about the fine points of whether treatment should continue for 6 months or 12 months or 18 months, and whether the dosages be 80 milligrams or 100 or 30 milligrams, and whether we should have one counsellor for 50 patients or 75 patients.

First, we've got to make treatment available immediately to those who need it and who want it.

Thank you.

[The prepared statement of Dr. Newman appears on p. 100.]

Mr. RANGEL. Thank you, Doctor.

Do you have anything to add, Dr. Cooper?

Dr. COOPER. No.

Mr. RANGEL. Mr. Akaka?

Mr. AKAKA. Thank you very much, Mr. Chairman.

Dr. Newman, it seems to me that your priority is not in the number of centers, number of professionals who are available to assist addicts, but really what you're asking for are the resources to be able to provide treatment for as many individuals in our country who require such treatment.

You have described a picture of communities that's very dismal, a picture that points out that an addict is really lost in that community, unless they can get treatment when they need it.

And, so, it comes back to funds to assist such centers, and to me this is the crux of your concern here and it's mine, too. Let me ask a question which is somewhat unrelated to funding.

Do we have a system, an organization, in such a place that has been set up effectively, to deal with this kind of problem?

Dr. NEWMAN. Yes, sir. I would not be true to my professional code as an administrator if I were ever to suggest that money was not an absolutely critical problem. Sure it is. But I must say that in terms of making a treatment alternative available—not the cure for addiction, but a treatment alternative that's effective and available—I really do not believe that money is the key issue.

In New York City, only about 10-12 years ago, there was an out patient detoxification program with no more than five clinics in the entire city. They were run on a very, very small budget. These five clinics accommodated over 22,000 admissions per year for short-term detoxification.

I don't suggest for a moment that a significant proportion of those 22,000 addicts were cured of their addiction. One doesn't cure addiction in 10 days, but at that time it was possible to advertise in every subway car in New York City, big posters saying if you're addicted to heroin, there is a treatment alternative available to you today, and you can phone such and such a number for the clinic closest to your area of residence.

So this has been achieved in the past without any tremendous outlay of money, and without any extraordinary network of clinical facilities. There's no reason why it couldn't be done again, and it would not take very much money.

There's only one thing it takes. It takes a commitment. It takes a commitment no longer to tolerate the insane situation that people who have this problem—it is perhaps the number one problem in our country—and who want to get help for it, have to wait for maybe 6 weeks or 6 months to get it. That's just insanity. And, it need not be the situation because 10-12 years ago, we were in fact able to provide a treatment alternative for all addicts.

And today, in Hong Kong, where they have roughly 40,000 to 50,000 addicts, every single night on TV channels, they advertise the availability of immediate addiction treatment. They are no smarter than we are. They are certainly no richer than we are. It's just ridiculous that we don't have the same opportunity in this country.

Mr. AKAKA. Money is not the total answer. You point out that a few years ago, there was a system that worked.

Now, what is the difference between that system and the one that's being used today?

Dr. NEWMAN. The problem is that the detoxification network of five clinics, which were operating for a few million dollars, was closed about 5 or 6 years ago in the midst of the financial crisis in New York City.

I think it's a terrible tragedy that that happened. I think that's a decision that should be reversed and could be reversed with a relatively small outlay of money.

But, again, it requires the fundamental commitment that we will not tolerate a situation where there is no clinical alternative to the next fix of heroin. That commitment comes first; the pieces will fall into place very easily thereafter.

Mr. AKAKA. Dr. Michels, being with the FDA, what influence do you have in your shop on these detox stations becoming available again?

Mr. MICHELS. Well, insofar as resources, obviously the FDA does not have a role to play. As I indicated or alluded to in my testimony, our responsibility is for the approval of new detoxification centers or clinics that want to get into operation, and our responsibility there is to assure that those meet the requirements of the regulations. Once that happens, then I don't see that FDA has any kind of bar or presents any other kind of hurdle to this sort of program.

Mr. AKAKA. Thank you very much, Mr. Chairman.

Mr. RANGEL. I don't understand something. People are saying there's not enough money around to fund some of these programs, and even though you're involved in compliance, you're able to view them.

Do you concur that there should be more money available for the program?

Mr. MICHELS. I'm sorry, sir, that's not my field of——

Mr. RANGEL. That's not your yard.

Mr. MICHELS [continuing]. Expertise. Let me say that——

Mr. RANGEL. I mean, while you're seeing whether they comply, you don't have an idea of what the need might be?

Mr. MICHELS. I have no reason to disbelieve that more resources should not be put into the programs, such that, if you will, the demand is met, that every abuser or addict has some place to go specifically for medical treatment. FDA's role, however, is in assuring that that treatment meets appropriate standards.

Mr. RANGEL. OK. But, that need could be resolved by local and State government as your predecessors testified, right? The private sector?

Mr. MICHELS. From a variety of sources.

Mr. RANGEL. Mr. Shaw?

Mr. SHAW. Dr. Newman, you are on a day by day basis connected with the working of a methadone clinic, so that you can give us firsthand testimony exactly what is done procedurally with—from the application to the treatment to discharge.

Could you walk this committee through that procedure, please?

Dr. NEWMAN. Sure. The first thing that happens is that an applicant who clearly and very desperately wants treatment and who is felt by the intake team to desperately need treatment—the first thing that happens is that he or she is told to go back to the streets to wait, maybe under very good circumstances 3 weeks, maybe 6 weeks, not infrequently 3 or 6 months. That's the very first thing that happens.

And the people who come to us expect that. They are the most motivated because they are the ones who apply even though they know there is no treatment available.

Mr. SHAW. Who is the team? Your intake team that you referred to?

Dr. NEWMAN. The staffing pattern in every clinic is fairly similar throughout the country thanks to the national regulations which dictate precisely what types of disciplines must be represented, and in most cases specifically dictate precisely how many patients can be accommodated by an individual staff member.

So the staffing patterns are very similar, and they go far beyond the doctors and nurses. They include social workers, vocational rehab specialists, counsellors, and a wide variety of other disciplines.

Mr. SHAW. Is this a committee that the applicant is before, and how many people specifically are made up of that——

Dr. NEWMAN. The actual procedures do vary from program to program. In our case, we have an application form which is fairly straight forward, which is reviewed by a knowledgeable, experienced counsellor with the applicant and subsequently there's a medical examination by the physician who works in the clinic.

Once the person is lucky enough to have——

Mr. SHAW. Now, that is required?

Dr. NEWMAN. Excuse me?

Mr. SHAW. The physical examination by a physician is required?



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Dr. NEWMAN. Absolutely, yes. The physical exam is required, a history is required, and to a large extent the specific questions that have to be asked and answered are spelled out in regulations at the Federal and State level. The type of screening and laboratory tests that have to be performed are spelled out.

In fact, throughout the country, every single person who enters methadone treatment has to sign a consent form that is actually written by the Federal Government. So every aspect of the procedure is incredibly closely controlled and monitored, and I must say I agree fully with Mr. Michels that the monitoring system has not in any way been eased from the perspective of the program. That works extremely well.

Mr. SHAW. What do the consent forms say? What does that give consent to?

Dr. NEWMAN. It basically says that I wish to have methadone treatment even though I realize that there may be problems associated with taking it. There are special qualifications for pregnant women. It says that the ultimate final word is not yet in regarding what side effects might be associated with methadone treatment.

I must say that I disagree totally with the rationale for that consent form. There is more evidence of the safety and effectiveness of methadone in the treatment of addiction than applies to virtually any other medication ever approved by our Government.

Mr. SHAW. It doesn't involve a consent for availability of medical records, criminal records, anything of that nature; this is more or less to protect the clinic; is that correct?

Dr. NEWMAN. No. The consent form may be misguided, but it is very clearly intended to protect the applicant. There are separate rigid—and I'm delighted to say, very rigid—confidentiality regulations also promulgated by the Federal Government that protect the privacy, the right to confidentiality, of the applicant. I'm delighted that those regulations exist and we abide by them scrupulously.

Mr. SHAW. When I was referring to the consent, is there any consent given for the clinic to obtain medical records for the applicant from previous——

Dr. NEWMAN. Sure. As a matter of routine, when we have an applicant who indicates that he or she has been in treatment elsewhere, for whatever condition, we ask for a consent to allow us to obtain records and information from whatever other agencies the person had contacted.

Mr. SHAW. And, this is a standard form.

Dr. NEWMAN. The consent form is standard, and the purpose of the consent is filled in, in each case.

Mr. SHAW. Do you have a copy of the standard application and consent form, all of the paper work that the typical applicant has to go through prior to consideration? Do you have that with you today by chance?

Dr. NEWMAN. No.

Mr. SHAW. Is that a standard form? So the one that you're familiar with is the one that's used nationwide? Is that a required form by the FDA?

Dr. NEWMAN. The consent for treatment is most definitely a standard form which is published by the Federal Government.

Mr. SHAW. Dr. Newman, could you make that—all of the paperwork that is involved by an applicant, available to this committee so that we might make it a part of the record?

Dr. NEWMAN. I'd be delighted to. I might say that the process is not nearly as cumbersome as my testimony might have suggested. It's fairly straight forward, and yet I think it's exceedingly effective in making sure that the applicant really does need the treatment that's offered.

But, it's really not complex.

Mr. SHAW. Mr. Chairman, I would ask for unanimous consent that the paperwork could be made a part of the record.

Mr. RANGEL. Without objection.

[See app. B pp. 158.]

Mr. SHAW. OK. If you would continue now beyond that, what happens then?

Dr. NEWMAN. We try, to the extent possible, to individualize the treatment that we provide to our patients. When somebody finally gets admitted, there is a very careful assessment by the physician, the nurse, the social worker as appropriate, and the vocational rehabilitation counsellor to try to identify all of the different areas in which we might be able to provide assistance to this particular individual.

A great deal of the assistance can be provided on-site by our own staff. In addition, we utilize whatever resources exist in the general community. All of the facilities at the back-up medical center—in our case, Beth Israel Medical Center—are made available to all of the patients. A treatment plan is developed jointly with the patient in terms of short-term and long-term goals, and that is constantly reviewed. And again, the Federal Government dictates how frequently there has to be a review of the treatment plan.

There also are stringent rules as to how frequently counsellors' notes must appear in the record, and the inspectors, I can assure you, review scrupulously patient records to ensure that their regulations, indeed, are met.

Ultimately, the experience is that the majority—certainly not everybody, but the great majority—of patients do well medically as well as socially. The medical condition improves markedly, and a very large proportion return—sometimes for the first time—to gainful employment. Family life generally improves, they get back again with their families that they frequently had no contact with during the period of addiction.

The question always is, what comes after that? My own feeling is—very, very strongly—that the decision whether and for how long to continue methadone treatment belongs under the purview of the physician and the patient, just as it does in any other medical condition. Virtually every patient—I would almost say every patient—wishes to detoxify from methadone at some point. Each year, in our own program, somewhere in the neighborhood of 20 percent of our patients in consultation with the physician, with the assistance of all of the staff, do, in fact, detoxify from methadone.

Unfortunately, the results have to be——

Mr. RANGEL. I'm sorry.

Dr. NEWMAN. Excuse me?

Mr. RANGEL. What did you say? I couldn't hear you.

Dr. NEWMAN. I said that, number one, the decision whether and when to detoxify should be reached by the patient and the patient's physician. And, number two, that in our own program, each year, roughly 20 percent of the patients ask for detoxification and are accommodated.

Some of those patients after detoxification do extremely well. Others do not do well. There is no question that there is a risk, a very real risk, associated with discontinuing a treatment regimen that has proven in a particular case to be very effective.

Mr. RANGEL. But, the patient has to request to be off methadone.

Dr. NEWMAN. The relationship between patient and counsellor, and patient and physician, is close enough that usually the initiative comes from either one or the other. It is not a situation where the staff is completely passive, and leaves it entirely up to the patient.

Certainly no decision would be made to detoxify someone without the patient's consent, and the reverse is also true. No requests by a patient after discussion with staff would ever be turned down, even where the staff does not agree that this is the optimal time to detoxify; it's really the patient who has to make that ultimate decision. And, as I say, around 20 percent of our patients exercise that privilege each year.

Mr. SHAW. How many successfully?

Dr. NEWMAN. In terms of remaining permanently abstinent, there are a number of studies which, without exception, indicate that less than half succeed. And half is not a bad number, but at least half are, in fact, unable to maintain permanent abstinence after detoxification——

Mr. SHAW. That's 10 percent. Does the other 10 percent or more than 10 percent go back to methadone treatment, or do they go back to heroin?

Dr. NEWMAN. Happily, a very large number of those people who leave the program and get into trouble do, in fact, seek readmission, and we do everything possible to expedite their reentry into treatment.

Mr. SHAW. What percentage do you look for as success?

Dr. NEWMAN. Congressman, I——

Mr. SHAW. I guess you'd have to consider under your guidelines, success would be permanent addiction to methadone.

Dr. NEWMAN. I don't view it as addiction. I don't want to quibble about the semantics, but it's clear that addiction has a very, very pejorative ring to it as used in our society. It suggests that——

Mr. SHAW. What are we talking about?

Dr. NEWMAN. While it may be pharmacologically correct to suggest that that's similar to addiction to heroin—which is one of the focal points of this particular hearing—I think it's totally wrong.

Mr. SHAW. But, we're talking about dependence on a narcotic drug, aren't we?

Dr. NEWMAN. We're also talking about dependence on a medication which is singularly effective in preventing the host of problems associated with heroin addiction. We're talking about dependence on medication.

Mr. RANGEL. Well, wouldn't heroin maintenance provide the same type of reduction in problem?

Dr. NEWMAN. Absolutely not. Pharmacologically, Congressman—and again I won't go into professional jargon—but the fact is that pragmatic reasons, practical reasons, make heroin maintenance impossible.

Heroin would have to be given three, four, five times a day. Its effectiveness is only about 4 to 6 hours. I pride myself on being one of the better administrators around, but it is impossible for any program to provide that type of medical treatment to more than maybe five, six patients, if that many.

It simply cannot be done. But, aside from that, we know that maintenance with methadone allows the great majority of patients to function in a self-fulfilling, productive manner. That has not been the experience in those settings where heroin has been given to an addict population. And we know what heroin maintenance does by looking at the street addicts in any city in America.

The self-administration of heroin by injection three, four, five, times a day is in no way whatsoever comparable to the effects of appropriately administered methadone in a clinical setting. One of the major mistakes that is made by journalists, by legislators and by the general public is that they fail to see any distinction between methadone treatment in clinical settings and the use of heroin.

Failure to see that distinction means that we're never going to come to any kind of agreement as to the role that methadone has to play as one component of the approach to the problem.

Mr. RANGEL. Well, if the gentleman will yield further, it's a little difficult for some of us to understand why you don't want to use the word addiction when someone has to constantly come to your clinic and see your doctors and receive a medicine in order to just live some kind of life, and you just don't believe that we should call that addiction.

Dr. NEWMAN. Congressman, if I might, on a personal level, refer to my 3½-year-old daughter, whom I think the world of. If that child had epilepsy, and had to receive phenobarbital to control seizures from her physician, If my neighbor or my wife or you or anyone else were to suggest that this beautiful little Jewish princess—actually half Japanese princess—were an addict to barbiturates, I must say I'd go completely bananas. That child with epilepsy receiving barbiturates in an addicting, dependency-producing dosage might be defined by Congressmen, by journalists, by the public at large, as being addicted. She would certainly be dependent on phenobarbital. But, Congressman, if you were to call her an addict, I must say I would take great offense, and patients receiving methadone——

Mr. RANGEL. Your daughter is not at 125th Street and Park Avenue selling her medicine like so many of the patients are, and there are many people that we just don't know when they can be detoxified and you say that's a physician/patient relationship.

But, I think it's a little different from someone who is born with a problem and the doctor diagnoses what they need, then to have a lot of people who obviously are able to get some type of euphoria out of the improper use of methadone.

Dr. NEWMAN. Congressman, that's not how it's used. The reason that there is a market on 125th Street, and there's also a market

on 17th Street and throughout the city, is because legitimate treatment—thanks to regulations, thanks to bureaucratic problems—is not available to tens of thousands of people. When there is that kind of demand, there's going to be a supply.

I think we ought to talk about specific data. In the recent Operation Pressure Point, which received a great deal of——

Mr. RANGEL. We have a program in the Harlem Hospital that they said their job was really not to rehabilitate or to cure, but to keep the level of addiction low so that the people won't be out there committing crimes.

In other words, it was just a way, you know, when you got up to $100 to $200 a day, you come in and get on methadone and get it back down to $10 to $15.

Dr. NEWMAN. I can't speak for others, Congressman, but speaking for myself, I'm a physician. I've been in this field for 15 years, and I view my involvement with methadone treatment as just that—a physician's administration of treatment. The fact that it happens to have very, very positive side effects for the general community in terms of decreased crime, makes me able to get some modest measure of support for what I do. But that's not my goal. I don't work for the Government. I don't work for the police department. My role is as a physician, to provide medical treatment that I know is effective, that I know is safe, to those who want and need the services that I can provide.

The Operation Pressure Point data gives us a real handle on how bad a problem, relatively speaking, methadone diversion—as it's called—really is. The head of that particular operation gave statistics on the drugs that were seized. There were tens of thousands of individual drug packets that were seized in the course of that operation in the lower east side. Methadone, illicit methadone, represented less than 1 percent of the drugs that were seized. Is that a problem? Sure it's a problem, but you're never going to solve it as long as there is demand for treatment that can't be met by the programs. As long as legitimate demand can't be met, there is going to be an illicit demand for methadone and there's going to be some supply to meet that demand.

Mr. SHAW. Mr. Chairman, I think we're getting a little bit far afield. I don't think that the question this committee is looking at is to the extent of the problem of methadone; I think what we're focusing on and trying to focus on now is whether it's an effective cure.

And, if I may follow my case study on the patient that has come in, I have a couple of questions, and I want you to proceed to follow it with him.

Has any background check been done of this individual before he's admitted? What do we do to check the truth of his story, of the information that he has given us? Do we check with the police files? Do we go back and check in his neighborhood? Do we talk to any of his neighbors? What do we do to verify that he's just not a darn good actor?

Dr. NEWMAN. Congressman, I don't know if you have ever been in a methadone clinic, but being a patient in a methadone clinic is a pretty horrendous state, given all the controls and regulations and monitoring and supervision, the attendance requirements,

having to urinate on demand, usually with somebody watching you do so. The problem is not trying to keep out nonaddicts who perhaps, because they are totally insane, want to get into a methadone program without needing to do so. That's not the problem.

Mr. SHAW. No. I——

Dr. NEWMAN. And that is not what we focus our attention on. When there is a question—and inevitably sometimes there are questions as to the need in the case of a particular applicant for treatment—we do everything necessary and appropriate, including checks with whomever, with consent, in order to find out whether that person needs admission.

But that's not a problem. The problem is accommodating those who definitely do need admission, not trying to figure out how to pick the one person who is trying to get in who may not need it.

Mr. SHAW. But, there's no—then, there's no routine background check made on these individuals?

Dr. NEWMAN. Background check? No, sir. I'm not sure what I'd be looking for. I'm worried about the medical problems, and we do, in fact, have a screening process for letting me as a physician know that this person needs my medical help.

Mr. SHAW. OK. The—you don't generally ask for medical records or anything of this nature?

Dr. NEWMAN. Sure. As I indicated, when it's appropriate, when it's considered necessary. Somebody comes in, for instance, and says that he's been treated off and on for hepatitis at some hospital. Sure, we try to get the records because we're concerned about all of the aspects of care of this particular person.

But, we do that with any other patient. If somebody applies for a hypertension program, we do exactly the same thing. Where it's indicated, we get the information.

Mr. SHAW. All right. How would payment be made to your clinic—and in what amount for his particular treatment?

Dr. NEWMAN. The reimbursement for our particular program is very largely medicaid, supplemented by some State funds, and by a very small amount of self-pay patients who actually pay for a clinic visit.

The cost per visit is somewhere in the neighborhood of $14. I think it's more reasonable to talk about the costs on a yearly basis, since the number of visits per week vary. That's somewhere in the neighborhood of $2,000 per year, and it really hasn't changed very much in the last 10 years.

One of the few things that the hospital does that has not gone up in the same inflationary spiral as everything else.

Mr. SHAW. Is the usual visit once a day?

Dr. NEWMAN. The visit is never more than once a day. The average number of visits of all our patients—we have 7,100 patients in treatment in our program—the average number of visits per week is somewhere in the neighborhood of three and a half to four.

Mr. SHAW. I don't mean this question to sound disrespectful, but I don't know any other way to express it.

Is this a profitmaking undertaking?

Dr. NEWMAN. That's not disrespectful at all. Profit is as American as apple pie. I wish I could answer "yes." But as a matter of fact, like every other service in my particular hospital—I might say

that I'm the general director of the entire hospital, not just the methadone program—we're a nonprofit voluntary institution. We rely in part on philanthropic support, and I welcome any contributions. But we are a charitable, nonprofit voluntary organization.

Mr. SHAW. Well, there are many methadone clinics that do turn a substantial profit from information that I have received, and I would say here that the gross amount received from your own figures would be somewhere over $14 million a year.

Dr. NEWMAN. That's right, for the treatment of over 7,000 patients.

I have never run a for-profit, private methadone program, never been associated with one ever. But I can't believe that there is the amount of money to be made that some journalists and others suspect, for the simple reason that the staffing that's required in those private programs, for-profit programs, is scrutinized with the same fervor, maybe more, by my colleagues in FDA and by the State and by the DEA as are the voluntary programs.

So, I can't believe there's that much money to be made, but maybe there is.

Mr. SHAW. Dr. Newman, you spoke in your earlier testimony of the confidentiality of the records. Are your records on each patient available to the FDA?

Dr. NEWMAN. Yes. the FDA inspectors do have access, as do the State inspectors. They are governed very stringently by Federal law that prevents redisclosure for any purpose whatsoever. But do they have access to everything we have.

Mr. SHAW. And, do they have access to the patients or do they ever go speak to the patients?

Dr. NEWMAN. They are present in the clinics during working hours, frequently for days on end, and certainly they have access to the patients if they would wish it.

Mr. SHAW. Mr. Michels, on page 5 of your testimony, you speak that—right at the very top, the comments that you have received on the notice of intent reveals a very general satisfaction with the regulations and standards.

From whom?

Mr. MICHELS. These are primarily from——

Mr. SHAW. These are the comments that you received.

Mr. MICHELS. That is correct. We went through the formal regulations development process that we customarily do at the Agency, and as I recall, these were primarily from people who are involved in the programs and State counterpart officials.

Mr. AKAKA. May I, at this time, Congressman Shaw—Congressman Ben Gilman has some questions. We'll take 5 minutes or so for more questions. We have a vote on, and we'll see whether we can continue with you or move on to the next panel.

Mr. GILMAN. Thank you, Mr. Chairman. I want to welcome Dr. Newman and our other panelists here today. I had the pleasure of meeting with Dr. Newman and his associates and a number of leading rehabilitation program directors in New York City yesterday, and the coalition for drug abuse, and I want to commend Dr. Newman and the Beth Israel Hospital for hosting that group and for spending so much time and effort in trying to provide a more effective rehabilitation and treatment program.

Dr. Newman, Beth Israel is probably one of the largest methadone hospitals in the Northeast, if not in the country; is it not?

Dr. NEWMAN. Yes, it is.

Mr. GILMAN. And, as I recall in my visit to your methadone clinic a little over a year ago or probably 2 years ago, you had quite a substantial backlog at that time.

How many are you treating now in the methadone clinic?

Dr. NEWMAN. We have essentially the same number of patients because our capacity has remained unchanged. It's slightly over 7,000, and we have a waiting list of between 1,000 and 1,500.

Mr. GILMAN. 7,000 per?

Dr. NEWMAN. 7,000 patients in a network of 23 clinics, which we operate, who are in treatment at any one time.

Mr. GILMAN. At any one time. Now, that would be 7,000 in a week, a day, a month?

Dr. NEWMAN. These are patients who by definition come in at least once a week; on the average, they come in three and a half to four times a week.

Mr. GILMAN. And, how long is the average stay in your methadone treatment? How long do they stay in your program?

Dr. NEWMAN. I would say the average is probably in the neighborhood of 2 years. We have about 500 patients who have been continuously active in our program for more than 10 years. We have a substantial number who have been in treatment for less than 1 year. The average, I would say, is about 2 years.

Mr. GILMAN. What's your backlog of people waiting to get in the program?

Dr. NEWMAN. In the neighborhood of 1,000, and I might say that if word were out today that we had room, I suspect we would have 5,000 applicants within the next 10 days, and I——

Mr. GILMAN. I yield back to my colleagues that these 1,000 are hardcore addicts who are dependent on heroin when they can't get methadone and they are out there on the street finding ways to get their heroin.

I've been reading this brochure that's put out by the News-Sun Sentinel, "Methadone, a Deadly Cure." How do you respond to the poisonous concept that they are saying this is the toxic substance and it's caused a lot of deaths?

What's your quick response to that?

Dr. NEWMAN. Congressman, I could keep you all week to respond to it. Let me just say in a nutshell that to my knowledge, no drug used in any form of medical treatment has received as much scrutiny by as many agencies for as long a period of time with respect to as many patients as has methadone, and yet has been found to be so extraordinarily free of side effects. I have never, ever, heard of a single case of a death attributed to appropriately dispensed medication.

I feel the article is absolutely wrong.

Mr. GILMAN. And, Mr. Michels, what about the contention that it's not adequately supervised by the Federal agencies?

Mr. MICHELS. I am sorry, sir, but I would just have to disagree with the tone and thrust of the entire series of articles.

Mr. SHAW. Would the gentleman yield to me on that?

Mr. GILMAN. Proceed.

Mr. SHAW. Mr. Michels, do you have any records of any deaths from methadone properly administered?

Mr. MICHELS. Not that I am aware of.

Mr. SHAW. Do you have——

Mr. MICHELS. I will double check to verify that and if so, supply it for the record, but as Dr. Newman has characterized his experience, I would say that is our experience as well.

[For the record: There is no information on such deaths.]

Mr. SHAW. Do you have reports of deaths from methadone abuse——

Mr. MICHELS. We have many reports of deaths associated with methadone, but as I indicated before, in the kind of populations that we're dealing with here, there are a whole host of other substances that are being grossly abused, and we have no information which would lead us to a conclusion that methadone is unsafe in the circumstances for which it's being used.

Mr. GILMAN. If I might reclaim my time because I'm going to have to run as we all will to the rollcall.

Dr. Newman, to your knowledge, is there any other acceptable maintenance program that could be substituted in place of methadone that's available for the public at the present time?

Dr. NEWMAN. With regard to maintenance, I'm not aware of any at all. But I do want to emphasize that I'm not suggesting that methadone be supported to the exclusion of other forms of treatment. There is a need for every form of treatment that offers any help to the addict population. Methadone simply has to be one of those forms of treatment. There is no other alternative.

Mr. GILMAN. And, I assume you recommend its continued use across the country?

Dr. NEWMAN. I certainly do, for everybody who wants it and who needs it.

Mr. GILMAN. Thank you. Thank you, Mr. Chairman.

Mr. AKAKA. Thank you very much, Mr. Gilman.

I want to thank the panel.

Mr. SHAW. Mr. Chairman, we are coming back and if the panel can stay, I have some further questions that I would like to ask of Mr. Michels. I don't anticipate any new questions of Dr. Newman.

Mr. AKAKA. Can you submit the questions or would you rather——

Mr. SHAW. Well, are we coming back or are we going to——

Mr. AKAKA. Well, we have two more panels coming up. I was going to call the next panel when we return.

Mr. SHAW. I don't think it would take too long. I wanted to question him on some of the answers that he gave to the questions that were raised in the Fort Lauderdale News-Sun Sentinel.

Mr. AKAKA. All right. Then——

Mr. SHAW. It shouldn't be too long. I would ask the patience of the committee to bear with me on it.

Mr. AKAKA. We'll take a recess now and return in about 15 minutes.

[Recess.]

Mr. AKAKA. Will this hearing come to order? Will the panel sit and we'll be ready to continue questions from Congressman Shaw.

Mr. SHAW. Thank you, Mr. Chairman. I thank you also for bringing the panel back for some additional questions which I have.

Mr. Michels, in referring to your testimony, the portion labelled allegations, on page 6, down on the fourth line, you refer to the report since the beginning of the methadone program, which is approximately 300.

Is that since 1977?

Mr. MICHELS. I believe that's since 1972, when——

Mr. SHAW. 1972, excuse me. Which was the date you gave us——

Mr. MICHELS. When the product was approved for these uses, yes.

Mr. SHAW. What is the—how many reports do you receive per year? You mentioned that you review and analyzed the 300. Is that all the reports that you have received?

Mr. MICHELS. That's per year, associated with methadone. We receive thousands of adverse drug experience reports on all of the products under our jurisdiction. I don't have those kinds of statistics available. So, this is a small portion of that.

Mr. SHAW. What I'm getting to is what procedures are you using in the analysis of the various reports?

Mr. MICHELS. OK. Let me give you a brief overview. We have a specialized component in the Center for Drugs and Biologics, which evaluates all adverse drug reaction reports. Specifically, each report is viewed as a single report as to whether it would be revealing anything alarming, unknown about that particular product and its use, and also reviewed in the context of other reports. For example, the first report of a particular instance of adverse reaction may not be alarming, but the fifth or the sixth may give you an indication of a trend. So, we are looking at it both from the individual report and the epidemiological aspects of that. I should also add, Congressman Shaw, that uniquely for methadone, we require the submission of adverse drug reaction reports for deaths from the clinics. Now, there is mandatory adverse drug reaction reporting from manufacturers for all products.

So, again, the scrutiny for this particular drug is well above and beyond that which is the average.

Mr. SHAW. OK. But, what procedures are used? Do you just review the reports that are submitted, or do you go to look at outside sources?

Mr. MICHELS. I'm not sure what you mean——

Mr. SHAW. Do you go beyond the four corners of the reports that you receive?

Mr. MICHELS. Yes, sir. We reexamine our complete data file on these reports. Reports are not exclusive——

Mr. SHAW. Maybe I ought to ask the question, what is in the report? Is it an individual case record that comes in?

Mr. MICHELS. It generally comes in on a standardized report form with information filled in.

Mr. SHAW. By whom?

Mr. MICHELS. By the reporter, that is generally speaking, the physician.

Mr. SHAW. All right. Then, do you ever go back to the source and do an independent investigation? That's what I'm trying to find out.

Mr. MICHELS. OK. I'm sorry. Yes, on occasion, we do where there is some questionable information or incomplete information. Something which just might have raised some suspicion about it.

Mr. SHAW. But, if a report appears proper and complete on its face, you do not?

Mr. MICHELS. That is correct.

Mr. SHAW. You say here, going on to the response to the next question, the second allegation as you term it; methadone is responsible for the deaths of thousands of people. We strongly disagree with this allegation, although many adverse reaction reports refer to patients who have died while on methadone, the reports do not provide any substantiation that the deaths were caused by methadone.

Are you answering this question by the report given to you by the physician who is reporting to you on the patient that was under his care, and, from that, do you answer the question? Is that what you're referring to in the report?

Mr. MICHELS. I'm sorry. I'm not quite following your question.

Mr. SHAW. My question, before I ask who sends in the report, you said these are made by the clinic, I guess, and signed by the physician on a standardized form.

And, you answered that if the form is complete and appears to be correct on its face, you accept it as it is and there is no random selection or you don't go behind the reports unless you're troubled by the contents of the report——

Mr. MICHELS. That is correct.

Mr. SHAW [continuing]. Or lack of content.

Mr. MICHELS. That is correct.

Mr. SHAW. Now, in answer to the next question, you again rely upon the reports in saying that there are no deaths attributed to methadone.

My question to you, is this the sole source behind your comment that people are not dying from methadone? The physicians who are treating the patients are reporting that they didn't kill any of their patients.

I don't mean to be facetious, but I want your to get the full impact of what I'm asking.

Mr. MICHELS. Sure. I think I understand the thrust of your question.

Certainly reports of adverse reactions that are evaluated individually and then collectively, that are in our information base, provide the primary basis for drawing that conclusion. But as well, as has been pointed out earlier today, there are a variety of studies that have been going on in other arenas which would not give us any signal in the environment that we have a problem in that arena.

In other words, physicians who have been familiar with the use of this drug in these particular settings are not raising those questions either. We have nothing from any source of information that might be available to us that would substantiate this allegation.

Mr. SHAW. Well, the problem that I see when we are looking at this, we're dealing with sort of a subculture anyway, at least the great majority of them are. Some of them aren't, but that certainly

would be the majority of them, and we seem to be, by the methadone treatment, pursuing a remedy of containment.

Now maybe that is the proper way to go, maybe there's really no cure and if we can just keep them from robbing 7-11's and mugging innocent people that we're doing a good job, maybe that's all we can expect.

But, because of the nature of the people that we're talking about, I'm not sure you'd really even know. Many of them have very sordid pasts, if not sordid present lives, and I'm not sure that their death is going to raise that many questions because there will be so many other ways to explain their deaths.

Mr. MICHELS. Yes, I understand the——

Mr. SHAW. My concern is that we may be, by analyzing the benefits of the program, accepting the reports of those who are administering the programs. Maybe we're really not going far enough and we should look forward to see exactly what has happened.

From the newspaper reports that you're referring to, I do note that there are—a substantial amount of deaths that are at least partly attributed to methadone, perhaps not exclusively, but certainly that these type of people are dying at much faster than the rate of the rest of the population.

Mr. MICHELS. Congressman, could I take maybe a slightly different perspective on this? You are correct in that the association of methadone with deaths in this particular population is terribly confounded. There is just no way to separate out what these people are doing to themselves, and isolate that methadone is a cause and the effect may be death.

I would also, though, focus on another population, that is those reports that we are aware of where methadone has not been associated with other substances of abuse at a particular point in time.

In other words, someone may have been off heroin and not abusing any other materials for a substantial period of time, and methadone may be attributed to that particular death. In those particular instances, to the best of my knowledge at least, the conditions of use of methadone have been such that it may have been purposeful overdose, that is the person knowing that he was taking too much, or accidental overdose for whatever reason, if one can attribute that sort of thing, or else an incomplete medical history. That is, a particular patient not revealing all pertinent information to the treatment physician, and, consequently, getting too much methadone prescribed. To the best of my understanding, though, those are very infrequent instances and are a risk of the kind of system that we're trying to operate.

But, we just, through all of the information available to us, be it report forms, other studies, just do not see that kind of association.

Mr. SHAW. I guess what's worrying me so much is that we don't have an investigative staff connected with this, that we are coming to our conclusions based upon the reports that are given to us, and I wish you'd correct me if that is wrong.

Have we ever investigated a methadone clinic and, if so, how many on how many occasions and what's been the results of that?

Mr. MICHELS. Dr. Cooper, did you want to address the first issue, and maybe I can come back?

Dr. COOPER. We have a number of reports we have provided to the committee, one of which looks at a study that we did in the seventies, comparing three groups. In that study we compared the number of deaths among people who were addicted to heroin who weren't treated, who were in drug free treatment, and who were receiving methadone treatment.

The study clearly demonstrates that the death rate was the lowest among those people in the methadone treatment.

That study was provided as well as a number of other pieces of information similar to that to this committee.

It is—to followup what Mr. Michels was saying—the population at risk here. It is very clear and it's long been known that untreated heroin addicts have the highest risks for killing themselves accidentally and intentionally of any other treatment.

Mr. MICHELS. And, again, let me reassure you that for whatever reason should adverse reaction reports or information come to our attention, involving a death where the circumstances may be unusual, too high prescription level of dose of methadone or whatever, that we will investigate and do.

Mr. SHAW. The chairman advised me that we are falling behind, but let me just ask you that question again, those investigations ever turned up any problems, any [illegible] of the——

Mr. MICHELS. They have not revealed anything beyond the categories of problems that I've just discussed.

Mr. SHAW. Thank you, Mr. Chairman.

Mr. RANGEL. Thank you very much, and we'll keep the record open in case Clay has further questions that may require some answers.

On the treatment panel, we have Dr. Mitchell Rosenthal, president, Phoenix House Foundation in New York; and Mr. Karst J. Besteman, executive director of Alcohol and Drug Abuse Association of New York, and, Dr. Rosenthal, we know that you have a time problem with us, and the Chair recognizes that, and will take your testimony, and you may proceed.

## TESTIMONY OF DR. MITCHELL S. ROSENTHAL, PRESIDENT, PHOENIX HOUSE FOUNDATION, INC., NEW YORK, NY

Dr. ROSENTHAL. Thank you, Mr. Chairman.

I'm Mitchell Rosenthal. I'm a psychiatrist and president of the Phoenix House Foundation. I'm also chairman of the New York Regional Chapter of Therapeutic Communities of America, which represents the major drug free residential treatment programs in New York State.

I'm a director of the National Federation of Parents for Drug-Free Youth. I've been involved in the treatment of drug abuse for more than 20 years, as the chief of the Navy Treatment Unit, as the deputy commissioner of New York City's Addiction Services Agency, and as the founder of Phoenix House, a drug-free treatment program.

Phoenix has grown over the years to include a variety of prevention and treatment services in both New York and California. We operate long-term residential programs and short-term outpatient programs. We work with adults, adolescents, and families, and we

bring drug education courses into schools and drug information programs into communities.

I am grateful for the opportunity to testify here today, and I think it's important for this committee to recognize, first, that drug abuse is very much a matter of perspective.

How it looks depends upon where you stand. And the view you get in Washington is a particularly grim one. Here you are at the receiving end of the statistics that document the seemingly inextricable grip of drugs on our society. But, there are places where the view is even more bleak, and they include many of our major cities.

In New York City alone, we have seen deaths by overdose rise by 20 percent between 1981 and 1983, and the number of babies born addicted increase as much, while the incidents of drug connected hepatitis rose by more than 50 percent.

Drug-related crime has increased sharply. Nearly one fourth of the homicides in the city are now drug related.

And drug abuse looks pretty hopeless in many of the Nation's schools, where the presence or the prevalence of drug abusers makes education increasingly difficult to accomplish.

It looks no better in our prisons or in our mental health facilities where a growing number of patients are also drug abusers. Yet, there is one place where drug abuse does not appear hopeless, and that's in treatment programs. Programs like Phoenix House because we do not see people getting sick or staying sick or persisting in their sickness.

What we see every day are people getting well, not all of them, and not all at once, but regularly, measurably and predictably.

We daily disprove the myth of drugs' invincible hold and see instead the invincible spirit of former drug abusers who are breaking their drug habits, taking charge of their lives, and returning to school, beginning careers, and starting their families.

Now, with all we hear and we see and we read about drug abuse, it sometimes seems that the best kept secret in the Nation is the simple fact that drug abuse is curable, that treatment works and that it is not only effective, but that it is cost effective to boot.

You will find attached to my testimony references to studies that document the kind of effectiveness treatment programs can demonstrate. Studies sponsored in part by the National Institute on Drug Abuse. The largest of these has shown that programs like Phoenix House, drug free residential programs, where the goal is abstinence, and where many drop out before completing the full 18 months or even a full 2 years of treatment, these people who are dropouts still succeed with nearly half who enter.

Our own studies at Phoenix House use a harsh standard to discover how many of our residents achieve what we call a best success, and that means that they use no drugs, that they engage in no crime, and that they are in school or employed full time.

We have found that 9 out of 10 graduates achieve the best success during the first year after treatment, and more than three quarters are still best successes 5 years later. Even dropouts succeed, and those who stay for at least 12 months stand a 50-percent chance of being a best success.

Now, the studies we have done have focused on long term residential treatment. It is time consuming therapy, but it is the most effective and most cost-effective treatment for those drug abusers who are most costly to our society. And, let me point out that most of the people that we're talking about are likely to be socially disadvantaged. Most are likely to engage in crime, and they are least likely to benefit from traditional mental health treatment.

Their drug dependency is less often the result of emotional conflict than of social impotence.

But, these are not the only clients drug-free programs can help. Long term residential treatment is not the sole method we employ. Our programs are both long term and short, residential and out patient, and designed for adolescents as well as adults.

At Phoenix House, we even operate a special residential high school with the New York City Board of Education. It has a 140-acre rural campus, and gives kids a second chance to make careers and to move on to college.

We have learned over the years that the key to successful intervention or treatment is a variety of service programs and a careful assessment of client needs and client strengths. We have learned that we can help just about any drug abuser, we can deal with all types, and all degrees of abuse with all kinds of clients as long as they are prepared to quit.

And, nobody can help either kids or adults who feel no social pressure to change, who feel no family demands to absolutely stop, and who have no fear of arrest or who have no fear of loss of employment.

What we have learned from the treatment has made it possible for us to mount a drug education program that is reaching more than 35,000 school children in the New York City metropolitan area each year, and we have been fortunate because New York City and New York State acted early and aggressively because they invested in us and in programs like ours and in programs quite different from ours, and they created a drug abuse service system that is unparalleled any place else in the country.

I don't think we should lose sight of the great role that has been played by the National Institute on Drug Abuse. It is their support and their research, their encouragement that has allowed the drug abuse field to develop in ways that it has, and that has made routine and accessible that which was once experimental and rare.

It has created a climate in which nontraditional approaches could rapidly prove their value and their legitimacy.

Let me point out to the committee that NIDA has only been able to do this because it has existed as an independent entity, free to set its own priorities, and it has been, in large measure, because of NIDA's support, that so many inner-city neighborhoods and so many of the Nation's socially disadvantaged are now served by programs based in their own communities.

I feel that any threat to NIDA's independence is a threat to the kind of drug abuse services that we have been creating these past 20 years, and the kind that we have proven will work. I do not believe that there is sufficient awareness of these methods and their effectiveness within the medical community today.

Doctors simply do not know as much as they should know about drugs, and if you're seeking areas in which the Federal Government can display enlightened leadership, then this is surely one. It is inconceivable to me, for example, that many doctors qualifying today as pediatricians have no more than a cursory understanding of drug abuse, which is the major problem of the adolescents that they will be serving.

The result is that these doctors will rarely look for drug abuse. No matter how often they see it, they frequently fail to find it because they hardly ever consider drugs when formulating their diagnosis. They do not examine for it or test for it or look for indications in their patient's medical history, and pediatricians are hardly alone. Other specialties are equally at fault. Internists and obstetricians, orthopedists, and even psychiatrists often fail to spot the drug problems of their patients.

And here is where the Federal Government can help by requiring more course work in drugs in our medical schools, by making this a condition of continued Federal support for medical education.

But, turning closer to home, let me urge the committee to recognize the pivotal role of drug abuse treatment, to realize that there is no way that we can confront drug abuse without adding to the heavy load already carried by treatment programs.

Certainly greater efforts in prevention are needed, but prevention will not work unless there is a road back for the kids who are now abusing drugs. It will not work in schools where a prevalence of drug abusers determine student values. Indeed, the first demonstrable effect of a successful prevention program is the identification of candidates for treatment.

Stricter law enforcement, as we have learned in New York during the recent police sweeps, produces more demands for treatment than it does for felony convictions, and that's what it should do, but the result in New York City has been to pack our treatment programs and put 1,200 drug abusers on our waiting lists.

The ultimate effectiveness of our efforts to confront drug abuse rests upon our capacity to treat and to cure the individual drug abuser. Thus, our response to drugs can only be as strong as our treatment program, and that is why I urge this committee to give first consideration to strengthening these programs.

In New York State, funds for treatment were reduced 5 years ago. Since then, Government support has remained much the same. There has been no increase to cover costs that have mounted year by year. There has been no way to raise capacity to meet the growing demand and no way to afford more than bare bones case.

And yet, the Congress seems determined in reauthorizing the ADMS block grants to deny New York State additional drug abuse funds. Now, I realize that it's awfully late in the game to talk about reauthorization measures that are now in conference committee.

Still, I believe that legislators concerned about drug abuse should recognize the inclusion of set asides and the shift toward a funding formula based primarily on population, that these pose serious threats to the existing treatment programs and are likely to draw drug abuse funds away from where they are most needed.



39-324 O - 85 - 5

I will not argue that the proposed set asides to expand treatment services for women is a bad idea, although I believe women are well served by existing sexually integrated programs. But, I can see no benefit to a set aside when additional funds are not guaranteed.

That would mean New York programs, already underfunded and unable to meet present demands, might well receive less Federal support than they do now. The shift toward an ADMS funding formula based heavily upon population will pretty much ensure that no additional funds will come to many of the States where drug problems are most severe.

Now, I do not know how alcohol and mental health problems are distributed, but I do know that drug abuse is not evenly spread across the country. Drug abuse is contagious, tends to cluster, much of it clusters in California and Illinois and New York. Indeed, State officials estimate that if present trends continue, we in New York will have more than 200,000 heroin addicts by 1988 and half a million users of cocaine and other equally potent drugs.

In light of that, I do not see the logic of limiting funds for New York and other heavily hit States to increase allocations for States which do not face the same size problem, and which have done nowhere near as much to help themselves.

What I ask the committee to bear in mind is that treatment is the basis of any effective response to drug abuse, resources must be made available to strengthen treatment programs, additional resources cannot be denied to areas where drug problems are profound and supplied to areas where the need is less; a strong and independent NIDA remains essential to sustaining the effective treatment capacity for the Nation; and greater understanding of drug abuse and drug treatment is needed by the medical profession, and the Federal Government should do all that it can to encourage it.

Finally, let me warn the committee that we are well past the time when half measures will suffice. The youngsters who began using drugs in high school have grown up. They are parents, they are in the work place, they constitute each year a growing proportion of our population. So, each year now, the percentage of the Nation at risk is increasing, and each year, the cost of drug abuse rises.

The cost in crime and in social services, the cost to our education systems, the cost to our criminal justice systems, and our health care and mental health systems. Each year, drugs cost our cities more, in declining public facilities, in qualities of life, in safety and security, in jobs, taxes and trade. And drugs are costing our industries, too, in accidents, in absenteeism, in morale, and in the quality of work.

Drug abuse becomes more costly each day, and the pity is that the problem can be beaten. We know how to do it, and we do know how to cure it.

Thank you.

[The prepared statement of Dr. Rosenthal appears on p. 103.]

Mr. RANGEL. Thank you, Doctor.

Mr. Akaka?

Mr. AKAKA. Thank you very much, Doctor. I just have a few questions to ask.

One is, how many people who enter your treatment program complete the total program?

Dr. ROSENTHAL. About 15 percent complete the total program. That is, would stay somewhere 18 to 20 months, and about 50 percent who enter the program would be there for as long as 12 months.

Now, those figures are very dependent on the way that laws are enforced. For instance, Phoenix House runs a treatment center in Orange County, CA. There is a much tougher criminal justice system in Orange County, CA, and the number of people who stay the required time increases proportionately with the amount of pressure.

In the same way that families that are willing to confront a youngster using drugs and demand that that youngster get treatment, are more likely to find that that youngster enters treatment than families who don't want to see the problem.

Mr. AKAKA. What type of followup services do you provide for——

Dr. ROSENTHAL. Followup services?

Mr. AKAKA. Yes.

Dr. ROSENTHAL. There are two kinds of followup services. The one I described here today was our research effort where, over the years, Phoenix House has followed as many as 3,000 of its former residents, and I would say that in the 17 years of Phoenix's history, we've treated as many as 25,000 residents.

The 3,000 have been research groups that we have identified by random selection and then gone out and found them a year, 3 years, 5 years, and 7 years later, so that we could do something about this followup research.

The other kind of followup that we do is to have an ongoing relationship with a client. I'll give you a typical example. A young man drops out of college at—or high school at age 17, comes into Phoenix House and remains a year and a half. While in Phoenix House, continues his high school education, and then while leaving Phoenix House, goes back to college or may even stay as a part-time resident in Phoenix House and go to attend college.

Then goes on to graduate school or goes onto the work place, so that the separation is a gradual separation based on an ability to perform rather than a fixed time.

I may or we may see some of those people a year or two years later, when they finish school, they tend to keep contact with Phoenix and especially with the clinical staff at Phoenix House who they have been very close to.

Mr. AKAKA. My last question has to do with finances. I noticed that 24 percent of your resources come from contributions. Where does the rest come from?

Dr. ROSENTHAL. About 55 percent of our total annual budget comes from grants, from Government, both State dollars and Federal dollars, and the balance come from fees that the patients may pay or their families may pay or the patients or residents or recipients of public welfare, then they will contribute those welfare dollars voluntarily to remain in the program.

Mr. AKAKA. Thank you very much, Mr. Chairman.

Mr. RANGEL. Doctor, what would be the annual cost for an addict to be treated at Phoenix House?

Dr. ROSENTHAL. If the addict was in our residential program, the annual cost would be about $17,000 per year. If——

Mr. RANGEL. And——

Dr. ROSENTHAL. The addict was in our evening program and was not in the residential program, the cost would run around $2,500 to $2,800 a year.

Mr. RANGEL. What would you get for the $17,000 as a resident, board, shelter, what type of treatment?

Dr. ROSENTHAL. He'd get shelter, food, clothing, medical services, legal services, and a full program of counseling and therapeutic activities that were designed to really reshape his or her life values, goals. We're very ambitious therapeutically. We take someone in who has become quite misshapen or who never had been shaped very properly to begin with and where drugs were an integrated piece of this lifestyle, and remove those drugs totally and help someone to learn to live with their pain, with their conflicts, with their feelings without having to use drugs ever again.

Mr. RANGEL. If the patient cannot afford the $17,000, how——

Dr. ROSENTHAL. Most of our patients cannot.

Mr. RANGEL. Well, what programs are offered to them?

Dr. ROSENTHAL. The patient can, the patient can have the full range—most of our patients cannot afford those fees. Probably in our residential programs, only about 5 percent of our patients are there paying their own fees.

The great majority of our patients, either their families are helping out to some small extent, or they are contributing their welfare allowance and the cost is borne through public financing.

Mr. RANGEL. And, contributions.

Dr. ROSENTHAL. And, contributions.

Mr. RANGEL. Well, how many people in New York are in residence?

Dr. ROSENTHAL. 550.

Mr. RANGEL. Is there a waiting list?

Dr. ROSENTHAL. Yes.

Mr. RANGEL. What would that be?

Dr. ROSENTHAL. About 150 today.

Mr. RANGEL. Is that the average waiting? What does that mean in terms of days, weeks and months?

Dr. ROSENTHAL. It usually means somewhere from 2 to 3 weeks.

Mr. RANGEL. Is there a type of patient that you would refuse?

Dr. ROSENTHAL. Rarely. There are times that we might not be able to handle properly someone with severe medical complications of the illness that might require more intensive ongoing medical therapy, but we've had people who have had serious illnesses in treatment, too. That would be one reason.

Another might be an ongoing mental illness of such severity that we felt that the client would be dangerous to other people in the program.

Mr. RANGEL. Well, if there's no serious mental or physical illness, then if you do have room, you'll accept all of the people who apply?

Dr. ROSENTHAL. Yes, and frequently, Mr. Chairman, we are 10 to 15 percent beyond our contractual capacity, sleeping two or three in a room that was originally designed for one.

Mr. RANGEL. Do you use methadone to detoxify your patients initially?

Dr. ROSENTHAL. Rarely. But, to some extent, that may be the fact that we are known as a drug-free treatment program and that patients who feel that they have a particularly high physiologic need would self-select and go themselves for methadone detoxification before coming to us. In about 5 to 8 percent of our admissions, we may see a need at the admissions office to refer the patient for detoxification services prior to admission to our program.

Mr. RANGEL. Were you here when Dr. Newman testified about this methadone being the same as this drug that his child, his epileptic child takes? Phenobarbital.

Dr. ROSENTHAL. I heard a little of that.

Mr. RANGEL. Did you hear any of his testimony about being sick and tired of this methadone being referred to as an addictive drug?

Dr. ROSENTHAL. Yes, I did hear that.

Mr. RANGEL. And, that he didn't like the idea that it was being called a dangerous drug, that it was a very safe drug?

Dr. ROSENTHAL. Yes, I think, if I might try to reconcile what may seem to be a contradiction, I see methadone as having an important place in the overall response to certain kinds of addiction, and then being useful in a limited time period.

Mr. RANGEL. He said he wouldn't take a person off of methadone unless the person asked for it.

Dr. ROSENTHAL. Well, I thought—maybe I hoped I heard him say that he thought there was a working collaboration between counselor and doctor and the patient.

Mr. RANGEL. Right.

Dr. ROSENTHAL. I do believe that because methadone treatment arose out of a framework that was very medically rather than socially and psychologically oriented, that their belief was that they were dealing with almost an organic or physical kind of disease and the analogy was often made in the early days of treatment that giving someone methadone was like giving a heroin addict—giving a heroin addict methadone was like giving a diabetic insulin.

Mr. RANGEL. Well, Doctor, that can very well be. When it all started, everybody was confused, no one knew what to do with them, and we were just pleased that people recognized that there was a problem.

But, you do have conferences, statewide, nationwide, you come together, you discuss the modalities and I guess people know now that it is curable without drugs, and others like the doctors almost saying that this is a one-way street, once you get on, somewhere you get off.

And, he doesn't think there's anything wrong with it. I don't—I am asking you for an opinion, not from where we were, but from where we are. Do you really believe that it's a safe drug that—is there any discrimination used in the applicant?

Suppose I end up in a clinic next door to yours that is a methadone clinic, is there any chance once I get into that clinic that I ever will know what drug-free therapy will be?

Dr. ROSENTHAL. There is a chance, it is difficult because the orientation of most of the work is in the methadone maintenance field, is to ongoing methadone maintenance.

I do think that that is changing. I hope that it changes further. I think that there should be a drug-free goal wherever possible.

Mr. RANGEL. Did you get the impression, Doctor, that a drug-free goal was a part of Dr. Newman's objective in treating patients at all? I don't mean to put you on the spot. I'm just really talking to you as a professional because I was rather disappointed in his testimony that the question of when do you wean off, how long the duration, the dosage, his attitude was too much focus too much time being paid to this, and that we ought to just find out whether these people are doing well being maintained on methadone. That was his testimony, and that until the patient asks to be taken off, he corrected that and said sometimes the doctor may recommend it, but they would never be taken off unless both parties agreed to be taken off.

Now, you're saying, too, that the orientation of these people may be such that the patient may not see a drug-free modality——

Dr. ROSENTHAL. I'm also saying that if the workers in a methadone clinic believe that they are treating an organic illness that is basically incurable——

Mr. RANGEL. You're very kind, Doctor, but we say in the Congress that providers normally support what is federally reimbursable or Government reimbursable.

And, if that's what they're selling, then that's the service, it really doesn't make any sense in trying something different because that's not what they get paid for.

Now, I don't know whether that's true or not, but, you know, you find a group of doctors, they get together and they have methadone clinics, and they are into methadone dispensing business.

Dr. ROSENTHAL. Let me put it in personal terms. I have three children. If one of my children were addicted, the last choice of treatment for me would be methadone maintenance. If it were the only option available at a particular moment, because that was the only thing that that young adult felt that he or she could use, I would accept that with great reservation and hope that the treating physician or treating group would be very limited in the amount of time that they would keep my child on methadone.

I do not see long-term ongoing methadone as the way for us to be going in terms of public policy or in terms of medical policy. May there be some exceptions to that? Some patients who need to be on for many, many years, yes, and I think that qualified physicians should make that judgment.

Mr. RANGEL. Well, Doctor, no one can disagree with what you testified, but we Members of Congress cannot enjoy the expertise that you do, and it just seems to me that somewhere along the line, there has to be a professional response where people are talking about methadone as though it's candy-coated gum, and that we should just take this as we take any other type of pill.

And, I think it's this type of attitude that has caused us to—I mean, he is saying drug dependency is no big deal as long as there is Government support. He has no problems at all with methadone maintenance programs. We never talked about rehabilitation. We

never talked about weaning off of the drug, and he seemed like he was offended if we talked about the dosage and the length of treatment.

Dr. ROSENTHAL. I think in fairness, the context that professionals like Dr. Newman, the context that they are talking about is that for those patients who are able to come to a positive socially—those patients who are able to work and be positive with their families and so forth, that for those people to be taking methadone for some period of time is not something that they as patients should be criticized for.

Mr. RANGEL. Yes, but you're not saying that—I hope you're not disagreeing that it's a question of which door someone knocks on, Phoenix House or one of these clinics. One is drug free and the other, you're saying, well, that's the orientation, that's what their training is and that's what they believe and, so, I don't take issue with it. One's an addict all of his life and the other may get cleaned up in 17 months. Plus there's a $15,000 difference.

But, over the long run, I'd suspect that you might make more out of methadone.

Dr. ROSENTHAL. Well, we have done some studies comparing the costs over longer periods. You can compare the costs over a 4- or 5- or 6-year period, then a drug-free program like Phoenix House becomes far less costly because the patient is now out of the program 12, 14, 18 months later and is drug free and is no longer any cost to the community.

Mr. RANGEL. Well, I just wonder, Doctor, whether a lot of the support that we get from methadone programs is not based on the fact that you're cutting down crime and you really get somebody to see—reducing his habit or reduced it to zero in terms of illegal drugs and that he's now dependent on legal drugs, and as long as these people are no threat to society and just a threat to themselves, why not subsidize it.

I hope I'm wrong, but I do hope——

Dr. ROSENTHAL. We also know, though, that many people who are given a substitute drug, that that substitute drug did not make them well, it did not teach them how to be wise, it does not teach them how to do time, it does not teach them a vocation, and it does not necessarily, if they are a car thief or a pickpocket, it does not necessarily teach them new skills.

Mr. RANGEL. Well, those that advocate heroin maintenance never said that they would make the person better. What they are saying is that it's better to keep someone subsidized with drugs than to have them hitting you over the head to get the price of drugs.

Dr. ROSENTHAL. But, that's a myth, Mr. Chairman. Even in the, you know, so-called English experiment where people have always maintained that if you give people all the drugs that they want, they're going to live happily ever after, indeed, they don't. There are two components.

If somebody has learned to deal with their emotional conflicts and life conflicts by getting high, then even if you're giving them an amount of legal dosage, whether it's methadone or heroin, they are going to want something else to go higher, to get further, and to change their state of consciousness.

So, whatever you have given them legally, they will augment, supplement, and take something else on top of it anyway with some other drug.

Mr. RANGEL. Did you inadvertently include methadone maintenance with the heroin maintenance? That's what you said. You said that where there was heroin maintenance and methadone maintenance, it doesn't work because the person would need something in addition in order to acquire their high.

Dr. ROSENTHAL. That's—I did say that, and I did intend to say that. I'm trying to say that one has to take a look at the entire lifestyle and life problems of the particular patient. There are some patients where methadone maintenance may be a desirable treatment for a finite period.

Mr. RANGEL. I don't get the impression as a fellow New Yorker that these patients come into this big screening multimodality center and their needs are evaluated by doctors and psychiatrists and after the drug-free modality doesn't work and only in those severe cases with the deepest reservations——

Dr. ROSENTHAL. You're quite right.

Mr. RANGEL [continuing]. Do they suggest that someone inject or drink methadone.

Dr. ROSENTHAL. You're quite right. To a great extent, it matters which door somebody stumbles into.

Mr. RANGEL. And, that's sad, and what is worse is that it appears to me that there is just no effort being made to substitute that addictive drug, that everyone is now addicted to methadone, that provide it.

There's just no search to find something that could serve as an antagonistic without becoming addictive.

Dr. ROSENTHAL. There's got to be some forces operating. Dr. Newman also testified that the average length of time in their program was 2 years.

Mr. RANGEL. He did testify to that?

Dr. ROSENTHAL. I think I heard him say that.

Mr. RANGEL. I guess—did he testify when Congressman Shaw was asking how do they know who they've got as patients? Your patient, how many clinics can he belong to at the same time for methadone? Is there any limit how many he can sign up for in how many communities?

Dr. ROSENTHAL. Well, you've got the wrong man here to ask that question.

Mr. RANGEL. I know, but I'm depending on you to try to give us some better direction to go because if we're going to make a mistake in terms of treatment and modality, I would like to make it on the side of drug-free modality. But, it just bothers me to see people giving out addictive medicine and just saying that maintenance is no big problem, and that we're spending too much time or percentage of doses and length of treatment, and I just wonder whether or not if it was someone's relative or friend, whether they would be that indifferent.

But, I do know that if you can keep somebody—I didn't say to make a whole perso.. out of them, but if you can keep them just waiting out there on 125th and Park Avenue for another dose of something, whether it's wine, methadone or a combination of pills,

that they are not prone to be running around robbing and beating on people.

In any event, I think what has happened in the last decade, Doctor, is that the modality people have come together and have decided that we all are going to do the best we can with the tools we have to work with, but I still have some deep-seated reservations. Not so much that we have to use methadone, but I just find in recent years, we are saying that there is very little alternative to methadone, that is by those people who are providing it.

Dr. ROSENTHAL. Well, that makes me—that there are insufficient alternatives, not only in New York but across the country that many parts of the country don't have any place to send their kids who are in lots of drug trouble. That's something that concerns me, and I'm sure concerns all of you——

Mr. RANGEL. Well, it didn't concern Beth Israel at all, and it just bothered me that there wasn't a plea for research and alternatives and not to knock what he was doing and does well, but I would not feel proud to have to treat people with that stuff.

Dr. ROSENTHAL. I concur with what you are saying. I remember once being consulted by a public health officer from a foreign country, who was considering what to do. They had no program at all in this country, and he asked me whether or not they should put in a methadone program, and I said, after you have put in a comprehensive drug free program, put in a very small methadone program and don't tell anyone about it ever.

Mr. RANGEL. Well, continue your good work. You certainly have served as an example as to what can be done in the Nation, and you will continue to have our support, and I only hope that we can get away from the addictive type of treatments. But, we can only do that with research and trying to find out whether something works better. Thank you.

I know that you're late and thank you for your time.

I'm sorry, Mr. Besteman, but Dr. Rosenthal had to leave. We're very anxious to receive your testimony.

**TESTIMONY OF KARST J. BESTEMAN, EXECUTIVE DIRECTOR, ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA**

Mr. BESTEMAN. If I may have the immediate privilege of following on to your concern about lengthy methadone treatment, several years ago, I would say this was about 6 years ago, when there was an analysis done of what was then the CODAP data system that was collected by the National Institute on Drug Abuse, the statistical pattern was that outside of New York City, the average methadone maintenance treatment consisted of 8 months of treatment, and inside of New York City, the average stay in treatment was around the 2 year period.

I think that goes explicitly to Dr. Rosenthal's point about the preconception of the clinician who is running the treatment program as to what the capacity of the patient and the cause of his addiction is. Because if I approach my patient as a clinician, that he has the capacity to live drug-free and the capacity to be restored, then even if I realize temporarily, I have to give him respite

from his life style of criminality and rushing from one shot to the other and hold him still for a period of time so we can engage with the use of methadone therapeutically, there is no great harm in that. In that clear, therapeutic plan, I would say methadone is safe. Methadone is appropriate and so on.

Mr. RANGEL. Why couldn't I say that if he doesn't take methadone, I don't get paid and if he does, I do get paid.

Mr. BESTEMAN. Well, that's an artifact of our reimbursement system, and the people who set the reimbursement system up don't think in terms of therapeutics. They think in terms of mechanics.

Mr. RANGEL. Exactly.

Mr. BESTEMAN. And, that obviously has some influence in the State of New York because of their peculiar, I don't like using the word peculiar, but they have a rather unique reimbursement system for drug treatment programs that many other States don't have.

Mr. RANGEL. I thought in New York you couldn't even apply for other benefits unless you were on a methadone program, so they encourage the patients to go——

Mr. BESTEMAN. I think that you will find you have to be in a State approved program. It doesn't have to be a methadone program.

Mr. RANGEL. They have a lot of doctors and everything.

Mr. BESTEMAN. But, I think your concern is well taken, and it is met in many other therapeutic settings where the term of maintenance is seen as part of a total treatment system and not an end in itself. And, nationally, I believe that's closer to the professional attitude toward methadone.

New York has uniquely had the vast majority of methadone patients since the beginning of the use of the drug, and has been more dedicated to its continued use among the clinicians that populate the New York scene.

Mr. RANGEL. Your programs, are they drug free?

Mr. BESTEMAN. And, we have people in our association who do have methadone treatment available, but, yes, drug free. In fact, philosophically, if I had to characterize the association, because we're both drugs and alcohol, and we have people who are in AA in our association and people who are recovering alcoholics, there is a great philosophical emphasis on drug-free life as sobriety not equalling being drug free, but then learning how to live somewhat in the terms of which Dr. Rosenthal talked about being able to deal with one's problems and emotions.

Mr. RANGEL. Your association are over the executives not with the patients.

Mr. BESTEMAN. We're with the professionals who do the treating, but if I had to characterize my membership, they would be more in committed to drug free as a treatment outcome by quite a majority than they would for maintenance.

Mr. RANGEL. But, if I was a doctor and I was getting paid to administer the methadone to patients, you know, per capita, how would you persuade me to be drug free as a member of your association?

Mr. BESTEMAN. Because I—if you were a physician and this was your major reimbursement mechanism, I would point out——

Mr. RANGEL. My only reimbursement.

Mr. BESTEMAN. Even if it was your only reimbursement system, I would point out to you that it's your obligation as a physician not to do harm, and that's part of your oath, and that, therefore, you have to do what is therapeutically beneficial to your patient, and to keep a patient on any treatment, and I don't care if it's some broad spectrum antibiotic, just because there's a reimbursement attached is unethical behavior for——

Mr. RANGEL. Well, I didn't mean it that way.

Mr. BESTEMAN. Well, but, it's the same—it is a——

Mr. RANGEL. If I had orientation that I was really helping someone physically with this addictive drug and that was my true feeling that the longer they stayed on, the better it is for them. The fact that I got paid every time they got a shot was secondary.

Mr. BESTEMAN. But, interestingly in the professional meetings that we hold and in the papers that we present, there are—I don't hear that being said anymore, which was being said very early on, and I'm talking about the late sixties and the early seventies, that this really was something somebody needed for a lifetime.

There is now more of the idea that there is a very, very small group of people who simply can't function without a maintenance drug, and the way to test how small that is is to keep encouraging the patients to become drug free, and that is more what is actually happening.

Mr. RANGEL. I am glad to hear that. Did you get that from Dr. Newman's testimony?

Mr. BESTEMAN. Dr. Newman was, I think, trying to make the greater point that he doesn't like to get into the details until treatment capacity becomes more available, but he did point out that 20 percent of his patients were being withdrawn annually.

He did point out the length of stay was about 2 years, and he did have a small group of patients who had been beyond 3½ years, and I think he even mentioned some patients are up to 10 years.

But, I think if you'd ask him to do a breakdown, you'd get into very small numbers at that end.

Mr. RANGEL. But, it's so difficult really to determine what's happening to a patient once they are off the rolls really.

Mr. BESTEMAN. OK. Well, Mr. Chairman, if I may, I would like to talk about the Federal effort for just a minute on the block grant, and about some of the things I think they can do in the Federal Government to exhibit better leadership characteristics to help us as a field and things that all of which cost some money, but I'm realistic enough to know that in this day and age, we are not in the position to ask for millions of dollars.

I would like to start by reemphasizing the fact that treatment does work, whether it's drug free or methadone maintenance. The statistics have shown consistently that patients benefit. Funding is not adequate to the treatment needs, and also drug prevention and education can be successful, but it has to be done, I think, with a couple of caveats.

It has to be part of a greater health education effort. To single drug education out as something that should just come into the curriculum at some point about the seventh to the twelfth grade, I don't believe, is workable. It has to be part of a total attitude and

behavior concern about health and one's personal responsibility that includes and goes directly as a precursor theme such as tobacco and alcohol because they are literally the starter drugs for precocious children, and I'm talking about age 9-year-olds and moving on.

With that, I would like to summarize directly some of the things that I think can be done through the public health service and the National Institute on Drug Abuse to be helpful.

One, I think there should be a clear Federal policy that the Federal Government is committed to sustaining a certain level of treatment capacity in this country. We had such a policy for about 8 years, and it was abandoned, and it has been eroding steadily since then

The attached material to my statement of the NASADAD summary of States, you'll read that State after State were cutting back, we closed three programs, we won't be able to do this, we've cut the quality and extensiveness of the services, do less with the same amount of money.

That has to stop because the number of casualties that are coming into the system is going up, and there has to be that clear policy. I don't hear it being stated by anyone at the Federal level.

There is no response to that important question. The second thing, I think, that the public health service and the Federal Government have to do is take leadership in defining adequate treatment services and evaluating new treatment techniques. Dr. Rosenthal referred to the fact that NIDA had been very active in developing new treatment techniques.

With the exception of a longer acting maintenance drug and a couple of antagonistics, which are still very much in experimental status, I know of no new treatment techniques that are being fostered or encouraged by the Federal effort, and people every day have to look at patients, haven't got the money to set aside to try that experiment that may or may not work.

The Federal Government has to take that leadership and say we will help discover these, we did in the past, it did in the past and it should continue that.

Mr. RANGEL. Have you ever heard of a doctor called Emmanuel Revici?

Mr. BESTEMAN. Yes, I was personally involved with him on two occasions.

Mr. RANGEL. Do you believe he has anything going for him in the area of rehabilitation?

Mr. BESTEMAN. The only explicit one that I evaluated was when he was using a substance he called perse, I believe. P-E-R-S-E. I was involved in that evaluation, and there was no data there to support his claim, and we looked into that extensively at the request of the then chairman of the Alcohol—Drug and Alcohol Subcommittee of the Senate, Senator Williams.

I'm familiar with him.

Mr. RANGEL. Well, they are trying to take away his license on quackery.

Mr. BESTEMAN. That has nothing to do with any drug abuse issue, though, as I understand it.

Mr. RANGEL. Cancer cure.

Mr. BESTEMAN. Yes. Because I have kept track of him a little bit.

Third, I think the Federal Government must restore its information system. You heard part of the data this morning from high school surveys. It's not our high school seniors who are coming into treatment, it's our dropouts. They are not part of that survey.

It is not the people who are in the household survey who have permanent known addresses so they can be sampled out of the community; it's the people without permanent residences or living in single rooms that are coming into our treatment programs. And, the data around the casualties in drug abuse have disappeared by decision of this administration to abandon the very important data set.

Now, it's interesting to me that decision has been made about drug abuse. No such decision has been made by the Centers for Disease Control in Atlanta, which is also part of the public health service, which follows measles. If you had asked Dr. Brandt this morning, and he is formerly my boss, I reported directly to him, I have high respect for him professionally, but if you had asked him where was the last outbreak of measles in this country, he gets minimally a monthly report, sometimes when things are a little hot, he gets a weekly report, down to eighteen cases in such and such a school district.

If you had asked him what is the latest drug of choice of the last 10,000 admissions nationally, there is no answer because the data system has been abandoned. You cannot make informed policy in the response around the treatment system without that information. The administration cannot make an informed recommendation and we can't intelligently discuss what ought to be the national response because we're all dealing with anecdotal material.

And, I am one that is very frustrated and discouraged person who has been in this field now well over 20 years, and helped put some of those data systems together, and now when you ask—should ask a reasonable question, I have to say the data has disappeared.

My informal survey gotten through the State council, NASADAD, is attached. That's not hard data that you were used to seeing 2 or 3 years ago. That has to be restored.

Four, I think the Federal Government must increase its services research activities. Prior to the block grants, under the old section 410, services research came out of money that was appropriated by the Congress to give services. It was clearly earmarked in there.

When the block grant came, that money was folded in and became part of the general services system. The research budget was considerably smaller for the institute. It is, in fact, doing services research. But, its actual expenditure on services research is less than half of what it was a few years ago.

The same mechanism, the same block grant impact happened to prevention research. Now, both of those research areas are being expanded slowly by the Institute within a limited research budget, but major needs of the field disappeared with the funding mechanism and the folding of that money into the block grants.

Fifth, I think we need much better policy guidance and development by the Federal Government. The field enjoys the strengths of

having experience... state and local experts capable and willing to test the usefulness of developing policy early in the discussion.

The policy forums that were so common to the Federal style, and I can name documents starting with the white paper in 1975 and other documents that came out subsequently, have all but disappeared.

Outside consultation is not encouraged. There used to be regular meetings between Federal officials and the big nine States, New York, Pennsylvania and so on. Those meetings have disappeared.

There is a whole series of interactions where policy was readily debated that no longer exist. Now, this is a very low cost, but very important way to gain a national consensus on what to do. It is gone.

Our association tries to provide that kind of forum with our annual meetings, with theme meetings in between, but with the absence of knowing where is the Federal Government as an actor, our States and our major private agencies that join are a little unsettled as to what they can plan on for next year.

There is no continuity, and this is a definite lack that I think the public health service could fulfill, either through consensus conferences, as NIH uses them, or with annual meetings such as the CDC has with its State health departments, with the counterparts.

Now, ADMHA does have this meeting once a year, but it is almost purely an informational exchange. It is short, doesn't give any kind of constant interaction, and at least the prior administrator of that agency said it wasn't that agency's job to engage in policy debate.

Now, if the agency can't engage in policy debate, then where does the public and the professional in the field engage in that debate? It's a very frustrating situation right now.

Finally, we are in an era of prevention. Everybody is talking about it. It is a top priority of the public health service. It is receiving attention from our association, from States, States are expanding their prevention, the block grant mandates prevention.

The amount of research being done to give firm underpinning to that activity so that when we introduce educational programs or introduce peer counseling programs, we know what the intended impact is, and what the unintended impacts are, it's simply insufficient.

Something in the neighborhood of 8 percent of the research budget is allegedly being put into prevention in NIDA. The fact of the matter is the States are mandated to do 20 percent, and the expenditures against treatment and prevention are really a larger percentage than that. We need more dedicated research in the prevention area to give guidance.

And, it's important that that priority be reemphasized. It took us, as professionals in the field, and in the combination of Federal, State, local, and private effort, if you recall, and I know you were around for most of this, and I can't remember if you were here at the beginning, but certainly from 1968 to 1976, to put together a treatment response in this country.

Eight years of hard effort and a fair Federal investment and dollar investment. We, I think, are at risk right now after watching

that system dwindle and not properly supporting it, of having it overwhelmed and having it collapse in the next year or two.

I don't think that that's an unfair assessment. If that happens, we're going to have to do it all over again because the drug abuse problem, addiction, is not going away. It is as severe today, the number of casualties coming at us is as severe today as it has been in the last decade. Now, I applaud the fact that high school seniors are more wise than a decade ago and less drug involved, but I cannot applaud the fact that there are heroin addicts, cocaine addicts, PCP abusers, just for starters, that keep coming at our treatment programs at a new level and that's not being responded to.

The people who run the treatment programs and are on the firing line day in and day out are being exhausted. If you look in the attached data with my statement, you will see States saying we have changed the counselor/patient ratio.

One State has now a counselor/patient ratio of 1 counselor to 100 patients. Now, I don't have to tell you there's not much happening therapeutically in that situation. And, that need of the treatment system is simply not being addressed, not being recognized, and not being responded to at the present time by the Federal Government. It is being responded to by only a few States that have done some additional commitment, and the private sector and the cities simply can't respond to the need at this point.

There's not enough research there. We've got to bring drug abuse back into a priority ranking in our domestic activities, and that's the essence of my statement.

Thank you.

[Complete statement of Mr. Besteman appears on p. 106.]

Mr. RANGEL. Thank you, Mr. Besteman.

Mr. Akaka?

Mr. AKAKA. Mr. Chairman, no questions, except to tell you that I appreciate your testimony and your warning to us about retaining those resources that are necessary.

Mr. BESTEMAN. Thank you.

Mr. RANGEL. Thank you. We will certainly be working hard in November to try to make those necessary changes you recommended.

Mr. BESTEMAN. Thank you.

Mr. RANGEL. Our last panel on prevention in the New Jersey Statewide Community Organization brings to us Mr. Charles Currie, chief of prevention, Division of Narcotic and Drug Abuse Control, New Jersey State Department of Health, and Ms. Gale Kavanagh, coordinator, Division of Narcotic and Drug Abuse Control, New Jersey State Department of Health, and Dr. Walter McCarroll, assistant commissioner of education, New Jersey State Department of Education; Detective Sgt. Donald Stumpf, juvenile division, Bergenfield Police Department, Bergenfield, NJ, and Ms. Josephine Zambrana, SCOP team member, Franklin School, Newark, NJ.

I thank all of you for coming to share your testimony with us, and we'll start with Mr. Currie.

**TESTIMONY OF CHARLES CURRIE, CHIEF OF PREVENTION, DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL, NEW JERSEY STATE DEPARTMENT OF HEALTH**

Mr. CURRIE. Mr. Chairman, members of the committee, I want to thank you for inviting me and my colleagues from New Jersey to testify before you about our substance abuse prevention efforts in New Jersey.

My name is Charles Currie. My official position is chief of prevention, in the State Department of Health, Division of Narcotic and Drug Abuse Control.

I and each of my colleagues will make a brief statement so that you will get a total sense of our efforts in New Jersey.

First, there is a definite need in New Jersey and in our country for sound validated prevention and intervention programs, that is to say, model programs to reach our people, especially our adolescent population, before they pass the dreaded line from no use to experimental use and misuse to full scale dependency and addiction.

A recent survey by the New Jersey attorney general's office indicates that there is considerable drug use in New Jersey schools. Add this to the fact that there are an estimated 35,000 addicts in New Jersey and some 12,000 patients presently receiving treatment in our system, of which 1,000 have been admitted in the last year for cocaine use, then the realization of the necessity for effective prevention and intervention services is indicated.

And, this is especially true, as other speakers have said, in the light of shrinking Federal and State dollars for treatment services in our State.

The second point I want to make is that we in the prevention unit, base our prevention efforts on this assumption, that drug or substance abuse is a community problem. It is, of course, a problem for the individual, who suffers physically and psychologically. It is a parental problem because the energies of the parents must be channeled into this problem for the individual drug user in the family.

It becomes a familial problem because the family dynamics are interrupted, scapegoating and blaming take place and a negative impact results. It's also a school problem because the youngster is a student, and grades generally suffer, absenteeism, and truancy, often occur.

The police also get involved when this activity is illegal. Elected officials in a community must be concerned because they allocate the resources to make the community a quality place to live in.

The point is that substance abuse in our view is a community problem.

The third point I want to make is that a community problem demands a community-based response, a community based model, and we think we have such a model in New Jersey.

It is the statewide community organization program, commonly and hereafter referred to as SCOP. The heart of the scope initiative in New Jersey is community organizing or better the process of community organizing.

The State prevention unit seeks to enable, to help communities to organize themselves by bringing together their leaders, shaping them into a smoothly functioning team, and through an intense training session, equipping them with the knowledge and skills they need to assess the problems of their community, to generate programs and activities that will respond to these problems.

The prevention unit supports these efforts through its efforts with technical assistance and followup visits. Note the State's role in this process is an enabling one, a facilitating role in a collaborative effort with communities and local institutions.

Rather than generating programs for communities to respond to and adopt, we say to the local communities, we will not program for you directly, but, rather, we will expose you to a process where you can help yourselves to identify and respond to your own unique needs and problems.

In effect, we help communities help themselves in promoting the behaviorial health of their own citizens, particularly their youth.

If this proactive effort is successful, we believe that the drug and alcohol problems of the community and other dysfunctional and related behaviors will proportionally decrease.

From 1978 to the present time, some 120 community-based teams have been trained and over 60 up to 70 percent are still active.

And, my fellow speakers will speak of the implementation and the outcome in each of the communities.

The results in promoting the behaviorial health and lessening dysfunctional behaviors in our communities have been substantial. Absenteeism from school, for example, vandalism, et cetera, drug related behaviors in many cases, have decreased. At the same time the evaluation of SCOP programs for fiscal benefits derived from our efforts indicate substantial savings to local communities.

Speaking of costs, the average cost to the State of implementing the SCOP program in a local community is about $4,000 to $8,000. This fee includes the salaries of State professionals, consultants, equipment, stipends, et cetera.

Needless to say, in this time of dwindling dollars for substance abuse prevention and treatment programming, the cost is relatively modest, the benefits great in terms of decreased human suffering and increased monetary savings.

Now, I would like to turn the microphone over to my colleague, Gale Kavanagh, who will expand on my remarks about the SCOP program.

[Complete statement of Mr. Currie appears on p. 123.]

Mr. RANGEL. Ms. Kavanagh.

## TESTIMONY OF GALE KAVANAGH, SCOP COORDINATOR, DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL, NEW JERSEY STATE DEPARTMENT OF HEALTH

Ms. KAVANAGH. Sir, I guess I'd like to begin my refocusing on and just remember that we spent the bulk of the day so far discussing treatment modalities and pros and cons of all of that.

Our focus is very, very clearly prevention. Prior prevention and early intervention for the community work that we've done, and it is mainly, as Mr. Currie said, an effort that tends to get people out

of what has become almost a national pastime, and that is scapegoating. If the police did their job properly, the communities say, we would not have so many problems with youth, that schools would shape up and do their jobs properly, we would not have so many problems with youth, and if parents, indeed, are certainly not what they used to be. They all work and they are getting divorced and separated and don't seem to care about children as much as they are.

And, what we, in our experience with communities, have said is that's probably all true anyway, let's get on with doing something. It is also mainly an effort to stop the rhetoric, which we have a lot of, about the problems with youths, and to get people mobile and action-oriented because our experience early on pointed out that most communities faced with problems with kids tend to do three things.

One is, of course, first deny the problem even exists. Second is that they can begin to suggest that it exists, to say it's really only a small percentage, and they are not my kids. And, I don't know what I can do to get involved. And, third, and probably most prevalent, is reliance on a crisis to catapault people into action, that's short-lived, but it has some effect. It is not pervasive certainly in terms of prevention.

What we began to do when we first formed the prevention unit in New Jersey was look around. We had very small amounts of money. So then you come up with the issue of do you fund one program, two programs, three programs and that's it. Or could we find any other way that would have a more pervasive effect, a rippling kind of effect.

At that same time, we uncovered a community that existed in our own State, which was receiving a good deal of local attention, State attention, national attention, and that was Bergenfield, NJ.

For what they were doing, the approach they were taking, which was mainly looking at building health rather than just treating illness with youth, not a particularly revoluntionary idea, but they were having success at it, and they had a particular way that they did this.

They formed a team of people and it had ongoing programming. I'm not going to go into the kinds of programs that developed out of that because they began to have real things that you could look at in terms of vandalism being reduced and absenteeism decrease because our next speaker will tell you exactly what they were able to do.

The programs that they came up with obviously only reflected that particular community, and we had no intent to form little Bergenfields all over New Jersey. However, we became convinced that the process of pulling together a certain group of people as problem solvers to address their needs was perhaps something that could be replicated at a low cost, be very creative and allow people some ownership.

I think the other point that's important for me is something that was said about 9:30 this morning, and that is the accountability issue. We as a State have that accountability factor built in, and I don't think that it is fair to any community, regardless of size and

demographics or problems, to simply back off and say it's your problem.

We have a responsibility to provide resources, support, anything that we can and so, in that aspect, the program has been different. What we have done literally then is contract with Bergenfield and said could you possibly teach other communities what you've done here, and began the process that became SCOP. What we said to communities also differed from other programs.

Community organizing, as everybody knows, is an old, old concept that's been done and redone a hundred thousand times, and will be. We said we wanted very particular people to participate in this. We wanted six or seven people from the community to come and some of those people have to be from schools, and we were not necessarily looking for kindergarten teachers, we were looking for a decisionmaker.

We also said you had to have police support, juvenile officers, we wanted involved, and anybody else from the community who was interested in enhancing youth. So that meant a kaleidoscopic group of people. Everybody from senior citizens to some youth themselves to mayors to town council, a host of characters have come through in these teams.

What we do is provide a 3-day training, once a community has responded yes. we're interested in the training, they go for—they are given an orientation first by a staff member because we want to make sure that people do understand this program.

We're not making any promises here. It's a real partnership. And, we also, maybe most important, want to make sure that they reflect the community that they are coming from because it's also been my experience that people do not. They come for a variety of reasons for these kinds of programs, lots of them very political. So, we want to make sure from the onset that we're all clear about what our agendas are, as best we can be.

They come to a 3-day training, and basically the training, very briefly, has two focuses. One is very simply, how to get a diverse group of people, diverse disciplines with their own agendas and the way they think things ought to go, to get into a workable cohesive force, and that's not sufficient because we did that hundreds of times in the sixties.

What we further have them do is teach them the program planning models, how do you come up with problems in a community, how do you begin to address them. At the end of 3 days, people literally leave with one, only one, concern, that they have all seven or eight people agreed upon, that they will begin to address in a program that they will begin to implement to address that particular problem.

The types of programs that have come out of this are just enormously varied, and then you'll see, because we have brought representatives from communities themselves. We're talking about being in communities that are rural, that are urban, that are suburban. Replicating this same process, and I just might add a footnote, that in an urban area, we make no pretense to go into Newark and say give me a team of seven people and we'll do Newark. We may be crazy, but not that so.

We take neighborhoods within an urban area and carve out small little pieces around one particular school, and Ms. Zambrana is an example of that particular kind of a concept, and will reiterate programs.

Just very briefly, some of the programs that have developed out of th s have covered a wide variety. Some have done primary programs. That means that they'll look at early intervening, first grade, second grade, third grader, who anybody can see are having a crisis situation in their life. People that they care about are getting divorced, getting separated, getting ill, moving, whatever.

That particular concentrated time makes it difficult for someone 6, 7, 8 to sit still and learn how to multiply. It can lead to lots of other things. We can wait or we can intervene.

One particular community chose a program to intervene early in that kind of way. Others have done outdoor programming. They have done leadership programming with youngsters. Have done a lot of programs that match up the elderly and youth. Have done programs that match up older youths with younger youths.

If you need other examples, you can talk about those later because you will hear them, and there is also included in the addendum, the cost effectiveness.

I guess basically, in summary, most of the programs have in key that we try to encourage people to start small, to do something that is possible for them, to do something that is visible, they will see it, the community will see it, they'll realize some success and a wonderful example is some of the things that Josephine will talk about in Newark.

And, also, the programs that involve youth have a sense of being needed and appreciated. We have found that's a powerful antidote to being substance abuser and any of the other problems that ensue off of that.

And, that this is only one approach. There is no pretense here that this is the way or a panacea or a miracle machine; it's simply one approach. We have had very interesting results. There's a cost-effectiveness study attached. And, our dollars seem to be returned manifold.

Detective Stumpf from Bergenfield really represents our prototype commur ity, and, so, I'd like him to talk about some of the programs and the results of what's happened in Bergenfield.

Mr. STUMPF. I'll locate Bergenfield for you. It is 6½ miles outside of New York City, your constituency.

Mr. RANGEL. Johnson and Johnson.

Mr. STUMPF. Bergen County. We're right across the bridge. We're 6½ miles from the George Washington Bridge.

Mr. RANGEL. Isn't Johnson and Johnson located there?

Mr. STUMPF. They are in New Brunswick, so we're a lot closer. Our kids can walk to your city, to your district. So, we are suburban/urban.

**TESTIMONY OF DETECTIVE SGT. DONALD STUMPF, JUVENILE DIVISION, BERGENFIELD POLICE DEPARTMENT, BERGENFIELD, NJ, SCOP TEAM MEMBER, BERGENFIELD**

Mr. STUMPF. In 1971, we got some Federal dollars from the Office of Education in some grants coming out of Washington, out of the Office of Education for communities helping themselves. I went away for some training in New York district, which was Adelphi University. Seven of us from the community of Bergenfield, a psychologist, a teacher, myself, a police officer, community people and made a team for this intense training.

We started to go about the business of looking at drugs and alcohol in the community. Decided that the way to do that was to mobilize the community and deal with the subissues that cause drug abuse, such as single parenthood, absenteeism, vandalism, those kinds of things.

We started to mobilize programs that did not directly take away alcohol or deal with marijuana or heavy drug use, and in—we were together 12 years. We now operate 28 such programs, such as for children that are dysfunctional with their families, programs for kids that are high risk, with single families and drug and alcohol abuse, and a whole myriad of programs that are community organized, community operated, that take no Federal dollars.

By this process that we learned, in the Federal training, about a very specific way in which to get problems together, bringing people from different arenas, political, the mayor, people that don't normally get involved, school people, the police, womens clubs, people that don't come together to form opinions and solutions, and it's amazing when you come at the same problem, somebody said today, it depends where you stand, and you come upon an agreement about what it is you want to do, to begin. It's amazing, the amount of energies that can be generated by people who were immobile before and that's what we faced in 1971–72, immobile, fear.

The drugs were coming out of New York, what can we do, our children are at risk, denial, just total isolation that we couldn't do anything at all. Becoming mobile, looking at the programs and starting to do education programs in the schools that dealt with drugs and alcohol, and one of your people said, these young people are intelligent enough to be dealt with honestly as we were doing kind of fairy tale stuff.

We did show and tell stuff, you know, that's bad for your health. Now we need to be more specific and by getting role models and peer counseling pressures where kids like this can be dealt with before they take the big step and end up at Phoenix House.

We have made a community mobile in 10 years that ultimately has done three major things for us. It has reduced the drug and alcohol involvement by 20 percent. I'm taking those stats by hospital incidents, overdose and medical treatment that I'm aware of.

We have increased our attendance in public schools from 86 to 94 percent. We have reduced the vandalism to public buildings by 65 percent, and reduced the amount of arrests of young people by 65 percent.

Seven people working for 10 years in one community, mobilizing that community, and taking people who were out of this process,

single parents, people on welfare, people who thought they had no voice, and making them mobile. We also get volunteers from that, and it continues as strong today as it was in 1972, and the Federal stipend was $3,000 for the original Federal training.

So that we now have been approached. We did great stuff and how can we get it out to the rest of New Jersey, and we got ahold of Mr. Currie and Ms. Russo, from Trenton, the State department of health, and said we'd like to do this with other communities. We would like to say that there is no magic here. We want to mobilize communities to deal with its own problems because Bergenfield's problems are different than Newark's problems. And, I don't proceed to say that Bergenfield's problems are the same problems as in your district because I've been in your district.

But, the people who live in your district know what the problems are and if they know what the problems are, they are very close to solutions. They need to get away from all those old experts who can tell us why we are failing and get some of the people that are effective that have not had a shot to come up with imagination and to come up with phenomenally new ways to deal with old problems.

We have done that, we have been able through the State's cooperation to train a hundred other teams who are out there doing programming on their own in their own communities and I could list thousands of programs that they do which are self-esteem programs. We have kids in our high schools calling senior citizens that live alone. There are programs that take the whole gamet of need of a social community, and what it does is gives responsibilities to the kids.

Most of our kids that we want to be responsible, and we give them no shot to do that. I see it as a police officer. I see the methadone you were talking about on my streets, that's supposed to be in some clinic in New York, and turned up on the streets in Bergen County.

So, you're right in saying that we do have those epidemics, but we need to start as early as possible. I would much rather deal with a 6- or 7-year-old dealing with his needs and his family, whether it be some kind of social support than with the senior in my class using that methadone and be heavily addicted to drugs.

So, I'm here to say that it can be done and the community effort is inexpensive, and it will continue, and I'm thrilled at my State has taken a look at that and is able to go from Bergen County to Cape May County and offer this training to the other people that need it.

So, I would defer now, because I do tend to talk on and on, I get very excited about this from my side, because I don't believe arrest is the answer. I don't believe methadone is the answer.

Mr. Bestemen, as I recall, said methadone was supposed to be for 5 percent of the population who had gone through all the programs and failed, and I don't understand how an 18-year-old can be on methadone, having had no program tries at all, and that—I'm not a doctor, I'm not saying that as a doctor. I just don't understand that.

But, Newark is a different place than Bergenfield and I'd like to defer to Josephine, who can tell you what that training impacted

in Newark. Now I know you know Newark and I'm sure you can identify with that.

Thank you.

Mr. RANGEL. Thank you. Ms. Zambrana?

**TESTIMONY OF JOSEPHINE ZAMBRANA, SCOP TEAM MEMBER, FRANKLIN SCHOOL, NEWARK, NJ**

Ms. ZAMBRANA. My name is Josephine Zambrana. I'm a parent. I work for the Newark Board of Education. I am a member of the bilingual advisory board in the State of New Jersey and also a member of the department of research, evaluation and testing for the Newark Board of Education.

Before I go into what SCOP has done for our community, and the school, I would like to read to you a profile about Franklin School.

Franklin School is located in Newark, NJ. As most large urban cities, Newark suffers the ravages of high unemployment, a serious crime rate, and a crumbling financial base.

Franklin is one of the 69 elementary schools in the Newark public school system, which is over 90 percent black and Hispanic.

If you visit the Franklin School area, you will see high unemployment, drug dealers and users, and a sign of poverty. Other indicators of the neighborhood's great want, could be seen in the number of burned out buildings, graffiti, and acts of crime and violence.

The community consists of a few lower middle class and working poor persons. However, the overwhelming majority are receiving public assistance and living below the official poverty line. The community is mainly Hispanic. More so Puerto Rican.

The functional capacity of Franklin School is a 839 students, but at the present time, the enrollment is 1,326. That's almost 500 over of what the school population should have.

I would like to give you a briefing in the academic achievements. On April 1978, minimum basic skills tests were administered to the third and sixth grade students. The results showed that only 35.75 percent of the students have achieved proficiency at the minimum basic skills level in reading and only 21.47 percent has passed the minimum basic skills in mathematics. At the present time these skills are much higher.

Discipline at Franklin School. Children arriving at Franklin did not find a quiet, safe, and educationally environment to live and learn. Instead, you will find an environment dominated by fear, violence, and disruptive behavior.

Students engage in fighting, setting waste baskets on fire, stealing and harassment of teachers. Teachers were often heard to say that they deserved combat pay.

Strategies implemented. One of them was to improve the physical appearance of the school. The second one was prompt maintenance.

Another strategy that was implemented was the involvement of SCOP. From Franklin School there were two teams trained by the Bergenfield team, and these included parents, teachers, senior citizens, and a policeman.

The following is a brief description of some of the projects implemented at Franklin School as part of the SCOP concept.

### A. WORKSHOP FOR PARENTS

Weekly workshops were offered in areas the parents selected as important to them such as legal services, social services, drug and alcohol, city government, police protection, helping with homework, and many other similar workshops.

### B. ADULT EDUCATION CLASSES

Survey forms were sent to parents and other community people to attend evening classes and to select courses or suggest courses of interest.

### C. OPEN HOUSE

Franklin School makes special effort to encourage parents to attend open house night. At this event parents talk with teachers, see samples of their child's work, discuss their child's report card, and visit other teachers who work with their child. The success of our open house night can be attributed to the care that is taken to establish an environment where parents feel welcome.

### D. QUE PASA NEWSLETTER

The Que Pasa newsletter was established as a means to communicate important events and activities at Franklin School.

### E. PARENTS HANDBOOK

A parent handbook was developed which include the school policies, teachers names, room numbers, school services, students and parents rights, and so forth.

### F. THE FRANKLIN SCHOOL ADVISORY COUNCIL

Letters were sent to all members of the Franklin School community inviting them to attend an open meeting. Out of this general meeting emerged a representative group consisting of school administrators, staff, parents, students, community leaders, central office staff, local police, fire department representatives and variouschurch leaders, and business people. The mission of the council is to identify existing problems and analyze them, help develop programs to ameliorate the problems and diligently implement them.

### G. LIVING ROOM DIALOGS

One technique that is used is to speak to a parent that is respected in the community and plan a meeting in his/her home, whereby other parents are invited to come and share concerns and suggestions for improving Franklin School.

### H. VANDALISM HOTLINE

In cooperation with the Board of Education Security Division, a 24-hour "Vandalism Hotline" was instituted which allows members

of the community to call and report vandalism or any suspicious activity observed around the school.

I. IMPROVE STUDENT INVOLVEMENT

Student involvement in school activities was a key factor at Franklin School. Franklin became their school, the staff worked with the students to make it a clean, happy, safe place to come to live and learn.

The students began to be valued and helped make important decisions about what went on in school. They were also responsible for doing much of the work and to keep it functioning smoothly.

Ethnic pride was very strong among the various racial subgroups—Puerto Ricans, blacks, and Italians—this was viewed as a strength and a starting point to begin building a sense of pride in the school. One cannot be proud of other groups, your school, or for that matter anything, unless one feels good about oneself. An outstanding example of an activity used at Franklin School to promote self-esteem was "balloon day" or "how far will your love go?"

Once the students began to feel better about themselves, they were more willing and able to join hands with others and accept more responsibility in maintaining a positive school environment.

In addition, they were involved in establishing their own classroom and school code of behavior. They were encouraged to participate in a variety of committees and were generally involved in the governing of the school. At Franklin School we have been involved in getting help from the police department and from different agencies to help our students in our school.

Also, at Franklin School doors are open to any parent or guardian that has a child in the school, to come in and talk about any problems that they may have.

Mr. RANGEL. I have to interrupt at this point. We're going to have to go to the House floor. But, we will listen to the remainder of your testimony as well as that of Dr. McCarroll.

I won't be able to return, but I certainly want to take this opportunity to thank all of you on behalf of the Congress and the committee, and certainly believe that what you're doing is a classic example of what can be done by other communities and we'll be sharing your experiences and your testimonies with our colleagues.

Mr. Cusack will be here for the conclusion of your testimony and that of Dr. McCarroll.

Mr. CUSACK. You may continue.

Ms. ZAMBRANA. I have finished.

Mr. CUSACK. All right. Then, why don't we have Dr. McCarroll give us his testimony.

Dr. MCCARROLL. I think at this point the most appropriate role that I can play is probably to wrap up the concepts and the importance of what we consider to be the key issues, the collaborative efforts within the communities and within the State.

**TESTIMONY OF DR. WALTER McCARROLL, ASSISTANT COMMISSIONER OF EDUCATION, NEW JERSEY STATE DEPARTMENT OF EDUCATION, AND SCOP TEAM MEMBER, SPARTA, NJ**

Dr. MCCARROLL. Prior to coming to the State department of education, I served for 16 years as superintendent of schools in New Jersey and was directly involved in SCOP programs and other kinds of prevention efforts.

I became convinced over the years from really both perspectives that the only way that a successful prevention program can work is if it becomes a total community effort.

On a larger scale, I think the same collaborative effort can apply to communities in between the department and state levels.

Let me just touch on two or three of the programs in the State department of education and the State department of health, that have joined together in providing for communities in New Jersey.

One of the programs, of course, relates to substance abuse. Most recently, the departments in a cooperative effort produced a reference manual on drug abuse, on student drug and alcohol abuse, a comprehensive planning guide to school administrators that we expect to be extremely useful to local school district principals and other kinds of administrators.

We have identified program models in the prevention, intervention and treatment of student substance abuse throughout the State. We have offered a series of regional substance abuse planning forums, again through the efforts of the department of health and the department of education.

These forums have a particularly significant aspect to them that I'd like to share with you, that being that those districts that decided to participate had to make a commitment in terms of looking down the road and pulling together programs, hopefully effective programs, for kids.

They have taken a very important first step. They have acknowledged that their community has a problem, and whether it's in New Jersey or in the other 49 States, I think that's an important first step to get rid of the denial aspects of a lot of communities and a lot of school districts have is a significant beginning.

In addition to those programs, a number of school districts have been identified and will comprise a pilot implementation project that will be offered during the 1984-85 school year.

There is also a number of in-service programs being offered by the Department of Health and the Department of Education around the State of New Jersey for people in communities and in school districts.

Let me simply conclude by saying that I think there is an important role here for not only the communities and the State, but I also think that there's a role for the Federal Government. I think aside from the interests that's being shown by the Federal Government for substance abuse, I think that interest must be expressed in the form of a commitment to programs like SCOP, to Departments of Health and Education and other agencies in the States, through funding for such things as research grants and so forth.

I can remember getting back to my early days in the SCOP program, when we became kind of overwhelmed by the kinds of

projects and the efforts that you're involved in and we kept reminding ourselves that we weren't attempting to change the course of history, but if we worked together, perhaps we could make a little difference.

And, I think this collaborative effort has been this cornerstone.

Thank you very much.

[Complete statement of Dr. McCarroll appears on p. 152.]

Mr. CUSACK. Thank you very much, and I think your testimony and your cooperative program is a great credit to you, and certainly probably one of the most encouraging things we have seen in a very bleak picture that comes before us in our travels around the country relative to confronting the abuse of drugs and all the breakdown in family life and in juvenile life.

And, we wish you well, and hope that you'll stay in touch with us here in this committee as we will with you.

Mr. LOWE. Sergeant, I'd like to ask you a question. I may be mixing apples and oranges here, but by way of foundation, how long has your program been in operation?

Mr. STUMPF. Twelve years.

Mr. LOWE. Twelve years. And, when you testified, you gave off some rather impressive statistics by way of reduction and negative occurrences associated with drug abuse.

Now here's where I may be mixing apples and oranges. When Mr. Russo testified before this committee at hearings in New York, concerning cutbacks as a result of the block grants for treatment and prevention, et cetera, he gave some rather alarming statistics in terms of New Jersey's overall drug problem.

For example, he pointed out, and I had not realized this until he did so, that New Jersey on a per capita basis, has the highest heroin addiction rate in the country, including New York, and that it is second only to New York in actual numbers of heroin addicts, and then, of course, he cited other statistics concerning other dangerous drugs, heroin, and so forth.

And, that New Jersey was really experiencing an enormous growth in its drug abuse problem. I guess what I'm trying to ask of you is, given what you describe as tremendous success in terms of your program, is that narrowly confined to your locale or is it something that is being successful throughout the State of New Jersey and you're seeing your results only on the school level and not necessarily on a broad base populous level?

Have I made my question clear?

Mr. STUMPF. Yes, you have.

I would respond to that by saying the numbers that I have given you are on a very confined level in the community which I represent, to which this program has been in 12 years.

Mr. LOWE. What is the demographics of that community?

Mr. STUMPF. That community is approximately 6½ miles outside of New York City, in New Jersey, in Bergen County. It's 2½ miles square and has 40,000 people in it. It is basically blue collar, alleged to be 90-percent white, and 10-percent minority.

Mr. LOWE. OK.

Mr. STUMPF. That's the community that I am a police officer in, have been for 25 years, and that's the community I speak of.

The other facts that Mr. Russo said are shockingly true. We have some very serious urban centers, very close to us, Paterson, which I think leads some of the numbers of uses of heroin addicts.

We are suburban in a sense, and the other numbers statewide have not, at that time, in practice, I don't think, to make that difference.

Mr. LOWE. OK. That's what I was leading into. Is there something in the nature of either the demographics or the community or to the fact that the other communities within the State of New Jersey have either not had the opportunity to start up this kind of program or has the State of New Jersey not forcefully—you see, one of the problems that we have seen in facets of this problem from treatment to prevention is that depending on the community, there's a great deal of interest and there's a great deal of suspicion that some of these glowing either programs or techniques are put into effect in certain types of communities, you know, white, light, bright and almost white.

I mean, it's the kind of thing that it follows a pattern, and I just want to ask you about this because Newark certainly doesn't have the kind of success rate that you're speaking of.

Mr. STUMPF. OK. Let me—I would just respond and defer to Gale. I believe prevention needs time in which to show its roots. I think you need to be at that business several years before your numbers change.

I do not think it is an impact such as an arrest, such as a flooding by police where you can instance action; I think it takes time for those—in other words, we're going to deal with elementary school kids. It takes us 8 years to get a school population that has had service.

I think that time is what shows the results of 12 years with us and not results with others because we've only been in the SCOP model for 3 years.

Mr. LOWE. Ms. Kavanagh, would you respond to this? This will be it for me. I don't want to hold you all, but——

Ms. KAVANAGH. Yes, I would, because Newark is of particular interest to me, not only because my office is there. They have had a program at Franklin, for example, two SCOP teams only for 3½ years, but interesting statistics even come out of that.

Such as, prior to their training, they had in the normal course of operation, three times a week, break-ins. That was just the norm. This year, they have not had one. Vandalism, break-ins, into the school.

Prior to 3 years ago when they did the national testing that goes across the board, they were at maybe rug level and verging underneath rug level in terms of reading scores, in terms of math scores.

In 3 years, they have dramatically—I mean, so much so that there was done another computer check to make sure those scores could possibly be right. So, they are particularly interesting environment to look at because of exactly what you say, that's said all the time.

This is sort of a nice little program to be blunt, white, and works well probably under $x$ number of conditions, with the right socioeconomic hardware equipped to it. And, I would suggest that's not been our experience.

Mr. LOWE. And, your commitment, too.

Ms. KAVANAGH. And, the commitment. Well, that's important anywhere. My experience is that commitment is no stronger at all in the intercity, given the right opportunity, and Ms. Zambrana tried to give people a picture of what Franklin was like before and after.

I think we have to examine that more. Our thrust actually for this year is more in the urban areas. It's a lot more work, absolutely, with this kind of thing, and the basic mistrust also.

Mr. LOWE. This will be my last question. The other skepticism that I have in assessing and analyzing a lot of these approaches is again, Sergeant, you speak of an operation in your town which, by the way, I mean, our laws—I'm not being critical of its existence, but I suppose what I am questioning is the drug problem, the essence of drug problems are far more concentrated in cities such as Newark, New York City, and parts of the city like Harlem and Bedford-Stuyvesant, et cetera, and, yet, a program of great success is in operation for 10 years in a rather small community and it's only in operation 2 to 3 years in an area like Newark.

And, I daresay that Newark's drug problem has been greater for the last 15 or 20 years than the community wherein you're located. Do you see my——

Ms. KAVANAGH. Yeah, I do, and I think that one of the answers is that most people have taken insular approaches to these particular problems. They believe their specific activity will do it. There are drug coordinators in every city around the State and all States for that practice.

Some of them strongly believe by giving out pamphlets they are doing prevention activities. I mean, I find that personally odd, but there is—you know, there is a firm belief, now we have taken a kind of multifaceted approach that's really difficult in the city. Granted.

Mr. CUSACK. Well, you know, to just make a comment on that, while sometimes smaller communities are reluctant and slow to grasp that they have a drug problem, once they do, they do something about it. The large urban areas, they accept the drug problem almost per se, and they accept it, and they accept it, and they accept it, and they don't do anything about it. Maybe it's for the small communities to show the way, turn a little light on.

Mr STUMPF. To me, Newark, and where Mr. Rangel is from, he's about 6 or 8 or 10 or 12 Bergenfields, and what our concept is, that's how it used to be dealt with. We cannot deal with the city of——

Mr. LOWE. Yes, I agree with you.

Mr. STUMPF. But, we can deal with Franklin School, and its five or six surrounding blocks, and all its parents. And, if we have a glimmer of a success there, then that can replicate at another elementary.

When you attempt to do urban training, you attempt to bring in urban—the people in Tower, they are so diverse that they become immobile.

So, we have said Franklin Street School, it's a small beginning, but the bottom line is it's a beginning, and I don't ever relegate the Bergenfield and Franklin would have the same atmosphere or any-

thing nor do I say that, but I say the process of training and of the ability to break that down that small is a beginning of change.

Ms. KAVANAGH. An interesting footnote is in the fall, CBS was just at Franklin School for 3 days of filming. It will come out—I probably went to school and was very impressionable—I modeled—programs.

I modeled urban area programs and they certainly are that.

Mr. LOWE. Thank you very much.

Ms. ZAMBRANA. Excuse me. I would like to add a little more on what Mr. Stumpf said in reference to Franklin School. At Franklin School, we have a great involvement of parents, and I think that in any community, if you're involved and have parents involved, things can be worked out.

Mr. LOWE. We have found that to be the case, Ms. Zambrana. Thank you.

Mr. CUSACK. Thank you. Thank you all very much, and this hearing is adjourned.

[Whereupon, at 2:36 p.m., the hearing was adjourned.]

# APPENDIX

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OPENING STATEMENT BY CHAIRMAN CHARLES B. RANGEL, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL, HOUSE OF REPRESENTATIVES

Good morning ladies and gentleman. This morning the Select Committee on Narcotics Abuse and Control will conduct a hearing on drug abuse treatment and prevention issues.

In our hearings across the country and in Washington over the past year and a half, we have heard conflicting testimony as to whether drug abuse in America is increasing, decreasing or leveling off. Notwithstanding these differing views, however, a number of critical facts clearly emerge.

First, drug abuse continues to be one of the most serious public health and social problems in our nation today.

Drug abuse costs our society an estimated $100 billion each year.

Drug use has escalated dramatically over the past two decades, particularly among our young people, and remains at unacceptably high levels. It is thought that levels of drug use in the United States exceed those in any other industrialized nation in the world.

From 1978 to 1982, cocaine related deaths and emergency room episodes jumped 300 percent and remain at high levels. Heroin related hospital emergencies rose nearly 80 percent nationally, and heroin overdose deaths increased almost 50 percent over the same period. In my own city of New York, heroin deaths rose from 246 to 528, a 115 percent increase, and remain high.

Second, states and localities are increasingly unable to meet the growing demand for treatment and prevention services. This is especially true in many of our nation's large urban areas that are hardest hit by drug abuse.

Over 94 percent of the States responding to a 1983 survey conducted by the National Association of State Alcohol and Drug Abuse Directors reported an unmet need for treatment and prevention services in their States.

New York City has a waiting list of over 1,500 persons who have sought treatment and been turned away because no space is available.

According to a recent survey by the National Association for City Drug and Alcohol Coordination, many cities report reductions in treatment and prevention services, waiting lists and gaps in services, and existing programs that are heavily overutilized.

Third, there is a strong feeling among State and local drug abuse treatment and prevention professionals that the Federal Government has abdicated its leadership responsiblities in this important area.

Federal funding for drug abuse services has decreased by about 40 percent under the Alcohol, Drug Abuse and Mental Health Services Block Grant.

State and local revenues and private resources have not been sufficient to fill the gap created by Federal budget cuts, leaving many states with the difficult prospect of trying to do more with less.

Technical assistance, public information activities and other forms of Federal support also have been cut back significantly.

In the words of one witness, the abrupt reduction in the level of Federal contribution to prevention and treatment programs amounts to "a simple abandonment by the Federal Government of the prevention and treatment field."

Today, the Select Committee will ask what the Federal Government is doing to meet the growing demand for drug abuse treatment and prevention services. We will review the activities of the Department of Health and Human Services and the Department of Education to see how well they are responding to the concerns we have heard from State and local treatment and prevention professionals. We will also hear reports on the current situation from treatment and prevention experts who are in the front lines of our fight against drug abuse.

Another issue the Committee will examine is the role of methadone maintenance in treating drug addiction. Methadone maintenance has been a controversial treatment modality. Questions have been raised regarding the safety and efficacy of methadone and whether it is appropriate to substitute dependence on one drug for dependence on another. On the other side, studies have demonstrated that clients who remain in methadone treatment show improvements in terms of employment and social functioning, decreased drug use and decreased criminal behavior. We will also look at drug free treatment alternatives.

Finally, the Committee will hear from a panel of State and local representatives from New Jersey who are involved in the Statewide Community Organization Program (SCOP). This community based drug abuse prevention approach has been successful in increasing school attendance, encouraging youth volunteer services, and reducing vandalism and other forms of disruptive behavior associated with drug use. We are anxious to learn more about this successful prevention effort.

I want to thank all our witnesses for taking the time and trouble to be with us today. We look forward to your testimony.

Before we hear from our first panel, I invite the other members of the Committee to make opening remarks.

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STATEMENT BY LAWRENCE F. DAVENPORT, ASSISTANT SECRETARY FOR ELEMENTARY AND SECONDARY EDUCATION

Mr. Chairman and Members of the Committee: I am pleased to appear before you as part of this panel to discuss the Federal role in drug abuse treatment, prevention and education.

As you are aware, the Department of Education is the sole Federal agency with a broad mandate to work with the nation's schools. The Department and its organizational predecessor have twelve years of experience in developing school-based alcohol and drug abuse education programs. The primary role of the Department in this area is to provide leadership, training and technical assistance to school systems for the purpose of developing local school capacity to deal with local alcohol and drug abuse problems using local resources.

The Department of Education supports the Alcohol and Drug Abuse Education Program which assists schools and communities to deal with the problems of alcohol and drug abuse. This program through five regional training centers and a program support project, maintains a national network for training, dissemination and technical assistance. Currently, 500 local schools and State agencies located throughout the country are part of the network. Each Regional Training Center, as part of its scope of work, provides available technical assistance to State agencies and local school systems. Much of this technical assistance is in the areas of program planning and curriculum development.

As part of its leadership role the Department, through each of the five Regional Training and Resource Centers, sponsors annual regional conferences to bring together personnel from local schools and State agencies concerned with prevention of Alcohol and drug abuse.

The Department of Education does not develop drug abuse education materials or curricula. However, curricula and materials are developed by a wide variety of organizations in the country, and a partial list is made available through the National Clearinghouse for Drug Abuse Information and Alcohol Information as well as the National Institute of Drug Abuse.

A prime component of the Alcohol and Drug Abuse Education Program is the school team approach. Team members are trained and then, in turn assist the faculty and administration of other schools in developing and implementing ways to prevent and reduce alcohol and drug abuse. The program has established school teams which reflect a variety of community interests and resources, and are supported with training and follow-up assistance, in every State and territory. A total of 4,500 school teams have been trained. These teams will affect approximately 736,000 young people annually. In 1983 alone, the five regional centers trained approximately 140 new school teams, while providing further training and on-site assistance to 360 school teams trained in previous years.

The purpose of the program is to work with these school teams until they become self sustaining groups. Each school team after training is expected to train additional school teams in its school system. For example, school teams in Wichita, Kansas have now trained 65 other teams in their district and will increase this to 75 teams by next year.

Another focus of the school team approach is the involvement of parents. To this end, school teams are encouraged to involve parent groups as the teams initiate programs in their schools and communities.

It is clear that drug and alcohol abuse and disruptive behavior have multiple causes in the community, family and school. Schools and parents can either exacerbate the problems or they can address these behaviors and become part of the solution. It is important that parents and schools work cooperatively to identify problems and offer constructive solutions, rather than behave as antagonists, each blaming the other for the problem and lack of solutions.

The program is also currently implementing a "System Approach in the Prevention of Alcohol and Drug Abuse" which focuses on the district superintendent and the school principal. As team leader, the principal must orchestrate the various programs in the school to reduce alcohol and drug abuse behavior. The district superintendent is responsible for providing leadership for all drug and alcohol related prevention activities in the entire school system.

The Alcohol and Drug Abuse Education program relies extensively on volunteer participation by school staff and community members and support from non-Federal sources. Again the backbone of this program is the team approach. The Federal investment for each school team is only about $20,000. About 166,000 volunteer hours are contributed over an average 12-month period. In addition, over an average 12-month period, the program generates about $1.8 million from non-Federal sources. This money, often raised through local community efforts and through local industry investment, is used to further the prevention programs in these communities.

In our 1985 budget we have requested $3,000,000 for this program. This is an increase of $150,000 over the 1984 level. With this funding we expect to continue those activities that are currently underway as well as expanding our efforts in discipline related problems in the schools. The increased funding will allow pilot schools to implement discipline-related programs through the school team approach. The results of the program can then be disseminated to a much larger number of schools through the Department of Education's Alcohol and Drug Abuse National Training System.

Mr. Chairman, as you know, the solutions to the problem of alcohol and drug abuse are as varied as the people who are afflicted. Some communities have been hard hit with this problem while others have been more fortunate. But, in each case, there lies the shattered hopes and dreams of families. Drug addiction, unfortunately, is too often the springboard to other problems such as crime, unemployment and child abuse. No one solution will work in every case.

The Department of Education recognizes this problem and understands that early awareness for children of the dangers of drug and alcohol use is one of the best methods of deterence. Our program, structured around the team approach, allows communities the freedom to develop policies and programs which best address their needs. The program is self-sustaining and once Federal support is withdrawn, these teams continue their work and serve as one of the most effective of our Nation's defense against further drug abuse.

I will be happy to respond to any questions you may have.

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STATEMENT BY EDWARD N. BRANDT, JR., M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman, and members of the Select Committee: I appreciate your invitation to appear today to discuss the Department of Health and Human Services' support of drug abuse treatment and prevention programs. The Administration is committed, through both supply and demand reduction activities, to the reduction of drug abuse in our society. In each of the past 3 years, nearly one billion dollars in Federal funds, exclusive of block grant funds awarded to the States, have been directed toward this goal. On the demand reduction side, the efforts of HHS are complemented by those of the Department of Education, as well as other Federal agencies.

We are pleased to appear today with the Department of Education, with which we share prevention information and approaches through interagency meetings on prevention, regional meetings of NIDA's National Prevention Network, and the Department of Education's five Regional Training Centers for Drug and Alcohol Prevention Education.

Within HHS, we conduct research, disseminate information both to the drug abuse field and to the public, and—through a block grant program—support State efforts for those who are currently afflicted by drug abuse and help prevent others from abusing drugs. All of these activities are designed to benefit our society as a



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whole, by reducing the demand for drugs. To this end, the President's Fiscal Year 1985 budget request would fund the Alcohol and Drug Abuse and Mental Health Services (ADAMS) Block Grant program at $472.3 million, an increase of $10 million over the Fiscal Year 1984 appropriation. Similarly, the President's Fiscal Year 1985 request for research activities by the National Institute on Drug Abuse (NIDA) is $63.5 million, an increase of $9 million above the Fiscal Year 1984 level—the largest percentage increase for any categorical field in the Public Health Service. Clearly the Administration feels that addressing the problem of drug abuse is an important priority.

So that we can better understand the nature of the challenge we all face, I would like now to briefly summarize the dimensions of the drug problem, before describing our current efforts to deal with it.

DEMOGRAPHICS OF THE PROBLEM

Drug abuse is certainly a major public health problem with unique characteristics. Drug abuse patterns change very rapidly, as demonstrated by the nearly 30-fold increase in marijuana use by young people between the late 1950s and the late 1970s. The steady increase in drug abuse has not been limited to marijuana; there has been a very substantial increase in use of most other drugs during the same approximate time. Additionally, unlike any other disease we face, there are illegal and highly profitable activities undertaken worldwide to actively promote drug abuse. The persistent nature of these activities causes society to devote billions of dollars each year to health, social, and law enforcement activities. Because drug abuse is actively promoted by a criminal element, it requires us to be vigilant and dedicated in repeating our prevention message to each new generation of youth.

The current levels of drug abuse by youngsters and young adults represent a totally new phenomenon as far as health epidemics are concerned. To underscore the current seriousness of the problem, particularly among youth, we must consider that despite our efforts:

Nearly two out of three young people try an illicit drug before they finish high school. (64 percent)

Almost one in every 18 high school seniors is actively using marijuana on a daily or near daily basis, and approximately 20 percent have done so for at least a month at some time in their lives.

About one in every 16 seniors is drinking alcohol daily, and over 40 percent have had five or more drinks, and/or been drunk, at least once during the past two weeks.

One-third of the American household population over age 12 has used marijuana, cocaine, heroin, or another psychoactive drug for nonmedical purposes at some time during their lives. In addition, about one in every five Americans in households surveyed have used one of these drugs within the past year. It is important to note, however, the encouraging side of this statistic, such as that two out of three Americans have never used any of these drugs.

In terms of the number of users nationwide, use of many drugs has begun to decrease. We are encouraged that among our youth there is increased awareness of the adverse health consequences of drug use which did not exist some years ago. These attitudes and the decline in usage are documented by a variety of sources, including our High School Senior Survey and National Household Survey, a variety of State surveys, and public opinion polls. Simultaneously, however, visits to medical emergency rooms related to the four most problematic drugs (cocaine, marijuana, PCP, and heroin) have risen sharply.

Thus, although the percentages of new and current users of most drugs in this country's population are decreasing or leveling-off, the adverse consequences associated with drug use continue to increase. This sometimes results in the appearance of seemingly contradictory trends; that is, a decrease in the overall number of users nationwide, but an increase in the number who are addicted and need treatment, and in the number of medical complications and drug related deaths as reported by hospital emergency rooms and medical complications and drug related deaths as reported by hospital emergency rooms and medical examiners. As a result, the encouraging signs in national and state prevalence surveys must be tempered by the realization that drug use by our young people continues to be viewed by leading experts as probably the highest in the western industrialized world.

The destructive effects of drugs on the health of those who abuse them are a major concern of ours. We gather information on the current, acute negative health consequences of drug use, such as drug overdoses, through the Drug Abuse Warning Network (DAWN). Through the DAWN data system, which is comprised of 758

emergency room and medical examiner facilities located primarily in 26 metropolitan areas throughout the United States, NIDA receives reports on drug-related cases on an ongoing basis. Although levels of use for most drugs have peaked or are beginning to decline, particularly among youth, patterns of heavier use, and use of more potent drugs, are present among numerous subgroups of users such as heroin addicts, cocaine users, and poly-drug abusers. This abuse has a significant impact on the health care system.

Instances of these apparently contradictory trends are evident when considering both heroin and cocaine. While use of heroin and other opiate drugs has not increased appreciably since 1981, subgroups of heavy users, by increasing their consumption, have caused an inevitable increase in the measures of medical and social consequences associated with these drugs.

Use of cocaine also has shown signs of leveling off among high school seniors, but the medical emergencies associated with more intense use of this drug are increasing at an alarming rate. The increases in the health effects of these very dangerous drugs, as well as temporary interruptions in their supply, may create surges in demand for treatment. In some localities these surges may be accommodated; in others, a temporary overloading of the existing treatment capacity results. The situation is highly variable from State to State and locality to locality, and among various user groups. For these reasons, we believe the ADMS Block Grant is the right mechanism to address these diverse needs. The Block Grant approach allows the States the flexibility necessary to deal with the highly fluid nature of drug abuse treatment demand. Let me now give a brief overview of the ADMS Block Grant as it applies to drug abuse.

### THE ALCOHOL AND DRUG ABUSE AND MENTAL HEALTH SERVICES BLOCK GRANT

Although Federal funding through the ADMS block Grant program continues to represent a substantial portion of the total revenue available to support drug abuse prevention and treatment services, the Federal Government since the mid-1970s has not been the major direct supporter of drug abuse treatment and prevention services. State and local governments, other public welfare programs, public and private insurance, and client fees have increasingly made up the bulk of total funding. For example, findings of the National Drug and Alcoholism Treatment Utilization Survey (NDATUS) from 1980 and 1982 demonstrate that while total financial support for drug abuse services has increased by 10 percent, the largest part of the increase in revenue came from third party payments, State and local governments, and in client fees. We realize that these are aggregate national data and that they may not reflect actual funding patterns in each State; nevertheless, they demonstrate evidence of the continuing diversity of financial support for drug abuse services.

The ADMS Block Grant program provides funds to the States in support of their alcohol, drug abuse, and mental health activities in the areas of prevention, treatment, and rehabilitation. It has consolidated a number of separate and somewhat inflexible categorical grant programs: alcoholism State formula grants, alcohol abuse and alcoholism project grants and contracts, drug abuse State formula grants, drug abuse statewide service grants, and community mental health centers grants.

This restructuring of Federal assistance came from our conviction that the States are better able to allocate funds for health programs within their boundaries than is the Federal Government. The tasks of identifying the specialized requirements of geographical areas, targeting resources on underserved populations, making resource allocations among competing needs, and monitoring the success of health service activities all require the kind of closeness and sensitivity to local conditions that are characteristic of State administration. Early results of studies conducted by the Urban Institute and the General Accounting Office indicate that States are effectively and efficiently using these Federal funds to address their own unique health care problems. States even have the flexibility to transfer funds among the different block grant programs. For example, the State of Kentucky has shifted a significant portion of the funds from their Social Services Block Grant to support alcohol, drug abuse, and mental health services.

Our experience has taught us that the basic philosophy was correct. All indications are that the block grant mechanism is working smoothly. This is in large measure due to the fact that States were already playing a major role in drug abuse treatment and prevention services prior to the ADMS Block Grant when States administered federal funds under drug abuse statewide services grants. The Secretary's Report to Congress submitted in January contained several examples of the ease with which States were able to implement the ADMS Block Grant. The

smoothness of the transition from categorical to block grant funding is perhaps best demonstrated by the fact that most States chose to begin operations under the block grant in the first quarter of 1982, even though the legislation allowed them a full year of transition. Because of their experience with administering the flow of funds in the categorical programs and their program knowledge, few major adjustments were required in States' financial and programmatic operations.

Simultaneously, however, at the Federal level it was necessary to implement a series of organizational and procedural changes to reflect our new relationship with the States. The Department has recently issued an official Block Grant Enforcement Policy that clearly states its statutorily mandated responsibilities while ensuring States maximum flexibility in the administration of their ADMS Block Grant program. The statute establishing the block grant makes the Department responsible for assessing State compliance with certain legislatively mandated provisions and, where necessary, for applying sanctions for failure to comply. These enforcement responsibilities include reviewing applications, annual reports and audits, conducting compliance reviews and investigations, and resolving complaints.

The application review process has been carried out smoothly and reflects improved cooperative relationships with the States through ongoing discussions of issues addressed in the applications. The process used by ADMAHA for the review and approval of applications has been used as the model for a new process to review State annual reports. This review is for both completeness with the mandated requirements for the report and compliance with all other aspects of the legislation. All of the initial State ADMS Block Grant Annual Reports we have received have now been formally reviewed.

In the two and one-half years of this program, only one formal complaint has been received concerning a State's implementation of the ADMS Block Grant. That complaint is currently under investigation. This fact further supports our conviction that overall, the ADMS Block Grant is operating in a manner which the States and their citizens find satisfactory.

### PREVENTION AND EDUCATION ACTIVITIES

As you know, under current law States must expend 20% of their alcohol and drug abuse block grant allotment for prevention and early intervention programs. As we indicated in our report to the Congress, most States increased their emphasis on prevention programming. Major State efforts to provide increased primary prevention and early intervention services include:

(1) Expanding Channel One programs, which involve joint ventures between business and government. These programs provide alternatives to drug abuse by offering work experience to at-risk youth. Such experiences are designed to convince participants that drug abuse is incompatible with their role as responsible and productive citizens.

(2) Encouraging the formation of Parent Groups designed to assist in the development of self-help strategies for parents to find ways of preventing drug abuse among their children.

(3) Developing prevention program assessment protocols designed to evaluate existing services and assist in resource allocation decisions.

In addition, we have received a copy of a report prepared by the National Association of State Alcohol and Drug Abuse Directors entitled "State Resources and Services Related to Alcohol and Drug Problems." This report indicates that approximately $144 millions was allocated by States for prevention services in FY 1983, of which approximately $50 million is attributable to the Federal share. In this survey each State alcohol and drug agency was also asked to provide information on projects and persons served in special focus areas, including prevention, intoxicated drivers, and employee assistance. The definition of prevention and early intervention contained in current law is very broad. This gives States great latitude in designing, implementing, and operating these programs.

### PREVENTION RESEARCH AND PREVENTION INFORMATION DISSEMINATION

The principal DHHS role in this process has been to develop, test, and evaluate new prevention and intervention strategies and to disseminate these results to State and local governments, the private sector, and other interested groups.

At the ADAMHA level we have established the position of Associate Administrator for Prevention to direct and coordinate prevention research and information dissemination in all alcohol drug abuse and mental health activities. Similarly within NIDA, we have established the Prevention Research Branch.

School-based preventive intervention research is a major focus of NIDA's Prevention Research Branch. Studies are conducted in selected schools to develop effective prevention approaches suitable for dissemination across the Nation. The effectiveness of existing prevention programs is also assessed for applicability for widespread dissemination to other schools. Eight school-based prevention research projects are being supported in FY 1984 at a cost of approximately $2.1 million.

The focus of NIDA's prevention research is primarily on programs for middle school and junior high school age students, the age groups in which vulnerability to drug use begins. Programs for senior high school students are also studied. Some of the approaches currently being assessed include: 1) programs that sensitize youth to social influences and pressures from their peers, family, and the media to use drugs—and teach youth to resist or "just say no" to these pressures; 2) social skills programs that provide training in a variety of communication and decision-making skills, as well as specific skills to resist pressures to use drugs; 3) personal value systems programs which help youth develop attitudes which are antithetical to drug use; and 4) therapeutic day-school programs for high-risk youth who are not functioning well within the normal school environment.

Research conducted over the last several years has demonstrated that the social influences approach can reduce the onset rate of smoking by up to 50%, during early adolescence. Preliminary evidence suggests that this approach is effective in preventing the onset of alcohol and marijuana at least in the short term. Among the research questions yet to be addressed are: 1) the long term effectiveness of prevention programs; 2) program effectiveness under typical classroom conditions; and 3) the effectiveness of programs with various cultural and ethnic groups. As promising approaches are ready for dissemination, we will conduct research on how best to achieve widespread adoption of these approaches by our Nation's schools.

Over the past two years NIDA has refocused its public education activities to reach a broad national audience. Building on findings from NIDA supported research, two national media campaigns were developed in FY 1982. The National Marijuana Education Program: "It's a Fact . . . Pot Hurts" was launched in May of 1983 through the Single State agencies to reinforce the growing perception of marijuana's adverse health consequences and help prevent its use among 11-13 year olds.

The National Drug Abuse Prevention Campaign is designed to reach parents and young people with drug abuse prevention messages through a broad range of media materials. The purpose of the campaign is to motivate parents to learn about drugs, talk to their children about the drug problem, and join with other parents to discourage drug abuse in their community. Building on NIDA research findings that teens do respond to concerns about the health consequences of drugs, NIDA is seeking to motivate young people to take appropriate action to resist peer pressure without losing status among their friends.

"Just Say No," the basic theme of the campaign and its message to youth, is being carried through public service announcements on television and radio, posters, and print advertising. At the same time, parents are being urged to get involved and talk to children about drugs. The support materials for the project include: "Peer Pressure: It's OK to Say No," "Parents: What You Can Do About Drug Abuse"; and six flyers on the health effects of commonly abused drugs.

Continuation of the Drug Abuse Prevention Media Campaign in Fiscal Year 1984 will reinforce the parent and youth themes for the general population and highlight these themes through appropriate materials for special target audiences in the Black and Hispanic communities.

Last year the Institute assisted the National Broadcasting Company in developing a media campaign involving its five owned-and-operated stations and its 200 affiliates. This program, called "Don't be a Dope," featured NBC television stars who presented messages about peer pressure that NIDA research has found effective in preventing drug abuse. Also included were a series of five minidocumentaries and a drug abuse quiz program hosted by Dr. Frank Field.

NIDA also assisted Peoples, one of the largest drug store chains in the country, in the development of its public education program for parents, "Drug Abuse: Spot It/Stop It." Composed of six drug and alcohol flyers, print ads, and radio spots, the campaign emphasized parent action protecting their children against drug abuse.

Drug abuse prevention messages carried as part of network television entertainment progams often are the result of NIDA technical assistance. Through the Scott Newman Drug Abuse Prevention Awards, the television community is rewarded for developing drug abuse prevention themes in national programming. In 1982 and 1983, the six winning programs were: "WKRP in Cincinnati; Pills" and "Quincy: Bitter Pills" (which dealt with "look-alike" drugs); NBC White Paper: "Pleasure

Drugs, the Great American High" (which dealt with the range of drug problems); "Cocaine: One Man's Seduction" and "Quincy: On Dying High" (which dealt with cocaine); the "Epidemic: Why Your Kid is on Drugs" (which again covers a range of drugs and drug problems). These programs reach millions of viewers with information about the effects of drugs on health and well-being. Despite more limited resources, NIDA continues to provide effective national leadership to public education efforts in the drug abuse field through these activities.

All of our prevention efforts build on a growing body of scientific knowledge about the health risks associated with drug abuse. These findings are consistent with and, we believe, largely responsible for, the public's increased awareness that drugs are not the harmless or benign substances which many in our society once believed they were. In fact, public attitudes about drug abuse have so changed in the past few years that our citizens now increasingly favor more vigorous enforcement of our drug laws.

Mr. Chairman, this concludes my formal statement. I would be pleased to answer any questions you may have.

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STATEMENT BY DANIEL L. MICHELS, DIRECTOR, OFFICE OF COMPLIANCE, CENTER FOR DRUGS AND BIOLOGICS, FOOD AND DRUG ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman: I am Daniel Michels, Director of the Office of Compliance, Center for Drugs and Biologics of the Food and Drug Amdinistration (FDA). I am accompanied by Dr. James Cooper, Assistant Director for Medical Affairs, National Institute on Drug Abuse (NIDA). As you know, the FDA and NIDA jointly regulate the narcotic treatment programs using methadone, and Dr. Cooper is here to answer any specific questions you might have relative to medical treatment issues.

I appreciate the opportunity to appear before the Select Committee to discuss FDA's role in the regulation of the use of methadone in the treatment of persons addicted to narcotics. I would like to begin my testimony with a brief history of the involvement of the Department of Health and Human Services (HHS) and FDA in this area.

HISTORY

In 1970, Congress enacted the Comprehensive Drug Abuse Prevention and Control Act (CDAPC Act). The Act's effect on FDA was twofold: (1) it authorized the then Department of Health, Education, and Welfare (HEW) to increase its efforts in the rehabilitation, prevention, and treatment of drug abuse; and (2) it required the Secretary of HEW to establish medical standards for the treatment of narcotic addicts. Subsequently, FDA approved methadone on the basis of well-controlled scientific investigations as a safe and effective drug for the treatment of narcotic addiction. (FDA had already approved methadone in 1947 for use as an analgesic.) As a result of this approval, FDA began to authorize the establishment of methadone treatment programs. In 1972 FDA published regulations that contained procedures for approval by FDA of treatment programs, mandated standards, and established procedures for revoking approval for failure to comply with those standards.

In 1974, in response to the need for clearer Federal authority and control in the regulation of the treatment of narcotic addicts, Congress enacted the Narcotic Addict Treatment Act (NATA). FDA's primary authority to regulate methadone treatment programs arises under NATA. The Act provides HHS the authority to establish standards for practitioners who use narcotic drugs for either maintenance or detoxification treatment of persons dependent upon narcotic drugs. In enforcing the Act, FDA determines whether a particular applicant is qualified under the standards called for in NATA to engage in maintenance or detoxification treatment. FDA also determines whether the applicant complies with the standards we and NIDA have established by regulation regarding the operation of methadone treatment programs. Furthermore, the review of initial applications is conducted by several States and by FDA concurrently. Thus, while FDA gives final approval for a narcotic treatment program, it is contingent upon prior State approval. The act requires that practitioners must not only comply with HHS requirements, but also must be registered with the Attorney General through the Drug Enforcement Agency (DEA).

Largely as a result of NATA and our desire to improve the operation of treatment programs, FDA and NIDA revised the methadone regulations in 1980. We designed the revisions to allow practitioners greater flexibility in using methadone to treat persons addicted to narcotics. We also revised the regulations in an effort to in-

crease the effectiveness of methadone treatment, reduce the likelihood of diversion by patients, and establish less confusing treatment standards.

FDA'S ROLE

FDA's basic role in the regulation of the treatment of addicts with methadone is to review and act upon applications for new or relocated treatment programs. Before approving any program, FDA receives assurance from the program sponsor that the program complies with other Federal requirements, such as those administered by DEA and State authorities. To Date, FDA has approved approximately 600 narcotic treatment programs in 41 States and 3 Territories. FDA has also approved 200 hospital inpatient detoxification treatment programs.

In an effort to ensure that narcotic treatment programs are properly administered, FDA also conducts onsite inspections of programs to ensure compliance with applicable statutory and regulatory reguirements. These inspections are routine and we inspect roughly one fourth of the total number of programs each year. For example, this year we plan to complete 130 on site inspections. We do not routinely inspect hospitals that provide inpatient detoxification treatment. We will inspect these institutions, however, if we become aware of a problem or receive a specific complaint.

Administrators of treatment programs are required to submit to FDA annual reports containing information on the amount of methadone used for treatment in a given year, the number of patients in treatment, the number of new patients entering treatment, dosage levels for clients in maintenance treatment, and the number of patients who receive take-home medication. Much of this information FDA shares with DEA for that agency's use in establishing production quotas for methadone and for assessing whether illicit diversion of methadone is taking place. FDA also reviews and thoroughly evaluates reports of adverse reactions arising in patients recieving methadone, alone or in combination with other substances.

As I mentioned earlier, FDA, in cooperation with NIDA, monitors the narcotic treatment standards under which the methadone programs operate. On September 13, 1983, FDA and NIDA published a notice of intent and request for comments on whether changes in the current standards are needed. Specifically, the agencies requested comments on whether the methadone regulations should be more flexible to accommodate changes in medical practice and whether the regulatons should be revised to eliminate recordkeeping, reporting, and other requirements that, because of changes in the state-of-the-art treatment, may be unnecessary or overly burdensome. Our initial review of the comments that we have received on the notice of intent reveals a general satisfaction with the regulations and standards.

To summarize, FDA's role involves the approval and clearance of specific methadone clinics, the monitoring of those clinics to ensure that they comply with our regulations and standards, the collection and evaluation of annual reports, the monitoring and updating of applicable standards as necessary, and the evaluation of adverse reaction date concerning the use of methadone.

ALLEGATIONS

In your letter of invitation, you ask that we discuss a number of charges which were made against the program last year in a series of articles in the Fort Lauderdale News Sun-Sentinel alleging mismanagment of the program and laxity of oversight on the part of FDA.

I wil now discuss the four most significant of these allegations in detail. I will, however, be glad to address any of the other charges or issues which were raised in the articles.

First allegation: FDA has failed to collect, analyze and act on Drug Experience Reports for treatment programs using methadone.

This contention is not true. We collect and analyze methadone drug experience reports prompty. Specialized medical officers review these reports to determine the extent and severity of any possible problem. For example, since the beginning of the methadone program, approximately 300 reports per year have been entered into our adverse reaction reporting system and have been reviewed and analyzed. Depending upon the seriousness of the reactions described in the repots, we conduct our own investigation and research into the likely causes of the observed adverse effects. Our investigation may, and on occasion has, resulted in onsite followup and inspection. We have established regular procedures for conducting the investigation and for determining the magnitude of a suspected safety issue.

Second allegation: Methadone is responsible for the deaths of thousands of people.

We strongly disagree with this allegation. Although many adverse reaction reports refer to patients who have died while on methadone, the reports do not provide any substantiation that the deaths were caused by methadone. Rather, the reported deaths appear to arise from the risk factors inherent in the population treated rather than from the use of methadone. For example, many of the reports involve persons with significant mental illness that results in suicide, homicide, or other violent forms of death. Other reports describe exposure, resulting from inadequate clothing or shelter, as the cause of death. In short the causes of death in these reports vary and range from no causal association to methadone use to purposeful overdose. In the latter instance, the reports describe methadone frequently as one of several drugs used in the overdose. Only rarely do we see reports where the overdose has been unintentional, or involves the accidental ingestion by a person not in treatment.

Third allegation: An example of FDA's lack of concern regarding the operation of methadone treatment programs is the Agency's reduction of its monitoring programs for compliance with statutory and regulatory requirements.

We believe that this statement has no basis in fact. We inspect narcotic treatment programs regularly to assess compliance with applicable regulatory requirements. Although the actual number of onsite inspections has decreased in recent years, the level of regulatory oversight has not. As I mentioned earlier, we are planning to conduct 130 inspections this year. In addition to FDA inspections and reviews, other Federal agencies, such as DEA, and the individual States regularly monitor treatment programs. For example, States in which large numbers of treatment programs are located, such as Michigan with 25 programs, California with 77 programs, Ohio with 11 programs, annually inspect each program within their jurisdiction. These States also conduct necessary followup inspections to correct deficiencies (8 in Michigan and 9 in California, for example). DEA and the States keep us updated on any significant problems discovered in their investigations.

Fourth allegation: FDA has relaxed its regulations concerning procedures and for approving and operating treatment programs.

Let me assure you that FDA has not relaxed its regulations. As I stated earlier, on September 19, 1980, the FDA and NIDA jointly published in the Federal Register revisions to the narcotic treatment standards, which became effective November 18, 1980. In light of NATA, we revised the regulations to make the clinical standards more applicable to a variety of program settings. We also revised some of the performance standards to contain clearer, more specific requirements.

The revised regulations have, in general, served the interests of patients and the public quite well. They have not hindered the provision of medical care for patients, yet they have helped to safeguard against illicit diversion of methadone. Although we made the regulations more flexible, we also strengthened them in many aspects. For example, the regulations now contain requirements for developing individualized treatment plans, for assessing patients' responsibility for handling take-home medication, and for delineating specific requirements for the medical director and program physicians. The current regulations, thus, strike a necessary balance between the risks of diversion and the benefits of enhancing a patient's progress towards rehabilitation and we believe that these revisions have resulted in increased quality care.

Mr. Chairman, this concludes my statement. Dr. Copper and I will be pleased to respond to any questions from you or the Committee.

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STATEMENT OF ROBERT G. NEWMAN, M.D., GENERAL DIRECTOR, BETH ISRAEL MEDICAL CENTER, NEW YORK CITY, NY

It is an honor to appear before you today, and to testify on a topic of such extraordinary complexity and importance to our society.

I am sure that no one on this Committee is so naive as to expect that I or others testifying today will offer any easy solutions. Speaking for myself, even though my own long-standing involvement in the struggle to contain addiction has been in the treatment arena, I have to disclaim any pretense that I know how to "cure" addicts. But while I admit to not having all the answers, after fifteen years of wrestling with the problem I at least have a clear view of the questions, and in my opinion none is as critical, or deserves higher priority, than this: how can we—legislators, public officials, medical professionals and the general community—ensure that treatment is available promptly to every addict who seeks it.

At the request of Congressman Rangel's staff, I will digress from this paramount issue only to comment briefly on the extensive series on methadone treatment

which appeared one year ago in the Fort Lauderdale News/Sun-Sentinel.[1] I am tempted to address each item of misinformation, and to point out the fallacies of each of the many unwarranted conclusions which the articles contain. To do so, however, would take more time than this Committee would wish to devote, and far more time and attention that the articles deserve. Rather, I would refer you to a monograph which was published within the last six months by the National Institute on Drug Abuse.[2] This monograph as the culmination of perhaps the most comprehensive assessment of methadone treatment which has ever been carried out. Although it is a Government publication, it embodies the exhaustive deliberations of no less than 43 highly qualified professionals whose expertise in the field of addiction in general, and methadone treatment in particular, is recognized internationally. These participants included psychiatrists and psychologists, behaviorists and statisticans, sociologists and social workers, obstetricians and pediatricians, pharmacologists and neuropharmacologists, chemists and toxicologists, and internists in a number of subspecialties. They have in their respective disciplines a wealth of administrative, clinical, educational and research experience which is probably unparalleled by any similar study group ever assembled. Members were drawn from Government at the federal as well as local level, and from the ranks of hospital administrators, program directors, clinicians, educators, and academic theoreticians.

The major conclusions of those extraordianry collective effort include the following, and I quote verbatim:

"There was unanimous agreement that the drug [methadone] is safe when used by physicians knowledgeable in the treatment of narcotic addiction. . . . A review of the pre-clinical methadone studies suggests that there are no major adverse consequences of prolonged use of this drug in humans, a finding consistent with clinical experience."

"The evidence presented regarding methadone maintenance indicates that while patients remain in treatment, their illicit opiate use and criminal behavior are significantly reduced. Most studies indicate that employment increases as well, albeit less dramatically than the other indicators. Since there is considerable evidence that higher doses improve retention, especially early in treatment, and result in lower levels of illicit opiate and other drug use, the use of methadone itself was considered to positively affect treatment outcome."

"To argue that methadone maintenance is not at least as effective as other available modalities for treating this population is to ignore the results of the best designed research studies and the consensus of a varied group of experts in the drug/mental health field."

"To summarize what is known about chronic effects and medical consequences of chronic use of methadone, . . . there are minimal side effects that are clinically detectable in patients during chronic methadone maintenance treatment. Toxicity related to methadone during chronic treatment is extraordinarily rare."

The conclusions were not reached hastily. They are supported by 750 pages of documentation. Nor is this resounding endorsement of methadone in the treatment of narcotic addiction merely a reflection of the views of experts in the United States. This past December I was privileged to serve on a Task Force convened by the World Health Organization, and comprised of experts from a number of European and Asian countries, as well as from North America. Essentiallly the same conclusions were reached: methadone treatment is safe and effective, acceptable to a large proportion of the addict population, and can be made available readily and on a large scale.

There is one criticism in the voluminous attack published by the Florida newspaper which deserves consideration because it does reflect a very real problem - indeed, the problem. The issue is the illicit market in methadone and the associated medical hazards which are attendant to the unsupervised, self-administration of this (and virtually any other) medication. Like all markets, licit as well as illicit, the sale and purchase of so-called "street methadone" is a function of two forces: supply and demand. Significantly, the common reference to illicit methadone trafficking is not "black market," a rubric which has been applied to items as disparate as cigarettes, penicillin and nylon stockings, but rather "diversion." This label very clearly reflects the popular view—of elected officials, journalists, regulatory and enforcement agencies and the public at large—that in the case of methadone it is the supply which is the primary problem. Demand, on the other hand, and the reasons for that demand, are ignored totally.

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[1] June 19–25, 1983.
[2] DHHS Pub. No. (ADM) 83-1281, 1983.

The fact is that there is a major demand for methadone on the streets of virtually every city in the United States. The cause is absolutely clear: there simply is no ligitimate methadone treatment available for tens of thousands of heroin addicts throughout the country who desperately want and need it. This is not a condemnation of the medication. It is not a condemnation of the programs that dispense it nor the governmental agencies that monitor those programs. And it is not a condemnation of the patients who are enrolled. Rather, it is evidence of our collective failure to provide a clinically effective alternative to the many addicts who want to stop heroin use but are told by clinics that they must wait many weeks and even months to do so. Being unable to obtain medication legitimately, they seek it through illegal channels. To denounce an effective medication because the demand for it exceeds the legal supply is simply stupid. It makes as much sense as suggesting that penicillin should have been condemned 40 years ago when throughout the world a black market existed in this life-saving product, on a scale which makes even today's international narcotics trafficking pale in comparison.

What suggestion—plea would be a better word—do I have for this Committee? It is simply this: the members, individually and collectively, should demand—not ask, but demand—that relevant governmental agencies at all levels develop immediate plans to eliminate waiting lists for methadone or any other addiction treatment, and to make such treatment available upon request to every single addict who wants and needs the help that it can offer. The same demand should be made of every physician and program director in the addiction field, and of every hospital director, health commissioner and county medical society in the nation. If you were to do so, you undoubtedly would receive in response many reasons why prompt treatment for all who need it can not be achieved. These alleged obstacles should be scrutinized one by one. Some will be dismissed by you as mere rationalizations intended to justify inaction. Others will be real, and will have to be addressed head on. In each and every case you must ask yourselves whether the alleged constraint to treatment expansion is so substantive that it justifies turning away people whose only option is to continue shooting dope. Is the goal of treatment upon demand attainable? Is it possible to make available a legal alternative to the next fix of heroin for each and every addict who needs it? And in making this judgment, I do not rely on either intuition or blind faith. I have seen precisely this objective met in two distant situations—one distant geographically and the other chronologically.

First, I would call the Committee's attention to Hong Kong, where I have served for the past ten years as official consultant to the Government on matters related to addiction. A decision was made in 1975 to provide access to immediate treatment to all addicts in the Colony. After considering various alternatives, it was concluded that only methadone treatment lent itself to rapid expansion on a sufficient scale to meet this goal. And indeed, the goal was met within approximately one year through the establishment of a network of outpatient clinics. The number of patients receiving methadone each day grew from less than 500 to over 8,000. For years now there have been public service announcements nightly on each of the major television channels in Hong Kong, advising addicts that treatment is available. One of the consequences of this massive expansion of methadone treatment has been that in the ensuing five years the number of addicts sent to jail—for drug-related as well as for other types of crimes—has fallen by an astounding 70%! And recently, when a successful law enforcement effort caused heroin prices to double, attendance at methadone clinics jumped 60% from one month to the next!

The other example is closer to home. In New York City in the early 1970's there was established a network of ambulatory detoxification facilities providing short-term withdrawal treatment through the use of gradually diminishing doses of methadone. Although there had been a concomitant expansion of long-term maintenance and drug-free programs, which had no difficulty attracting large numbers of addicts, these detoxification clinics at one point served more than 22,000 admissions annually. Posters were placed in all subway cars announcing that treatment was available upon demand. As was to be experienced in Hong Kong a few years later, access to a medically safe and effective alternative to heroin use in New York City was associated with dramatic evidence of improvement in the overall narcotic addiction scene: drug-related hepatitis cases, the addict population in prison, crimes typically associated with addicts, and overdose deaths all dropped precipitously.

And today? The New York City detoxification clinics have been closed due to lack of funding, and the long-term treatment programs (methadone as well as drug/free) are virtually all operating at capacity, so that treatment simply is not available. When Operation Pressure Point was conducted with much fanfare a few months ago, there could be absolutely no increase in enrollment because there were no programs to accommodate additional patients. Accordingly, while the supply of narcot-

ics may temporarily have been disrupted, and the prices increased, there is no basis for concluding that even a single addict gave up the habit.

I am not suggesting that methadone is a panacea, and I certainly do not advocate support of methadone treatment to the exclusion of other therapeutic approaches. The problem is simply too complex and the addict population too heterogeneous to think that any one modality, by itself, will be sufficient (and I would emphasize that both in Hong Kong and in New York City a decade ago, other treatment approaches continued to play a very major role). But the reality is that without methadone, the goal of making treatment available promptly to every addict who wants it can never be met.

The issues are not academic. Unlike Hong Kong or New York ten years ago, we can not put up posters or have public service announcements on television to encourage addicts to seek treatment. It would be tantamount to a store advertising stereos when all the stereos have been sold out and no new shipment is expected. Even Crazy Eddie is not that crazy. But far worse is the fact that addicts in most cities can not obtain treatment even when they come forward spontaneously, without any coaxing and without any legal pressure, in order to escape the enslavement of heroin dependency. Indeed, the only cities where there are no waiting lists for methadone treatment are those where such treatment has been outlawed altogether through legislative or regulatory fiat. This situation is unconscionable, and must be corrected. If humanitarianism does not motivate us, then pure self-interest should!

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STATEMENT OF MITCHELL S. ROSENTHAL, M.D., PRESIDENT, PHOENIX HOUSE FOUNDATION

My name is Mitchell S. Rosenthal. I am a psychiatrist and the president of Phoenix House. I am also chairman of the New York Regional Chapter of TCA—Therapuetic Communities of America—which represents the major drug-free residential treatment programs in New York State, and I am a director of the National Federation of Parents for Drug-Free Youth. I have been involved in the treatment of drug abuse for more than 20 years now—as chief of a Navy treatment unit, as deputy commissioner of New York City's Addiction Services Agency, and as the founder of Phoenix House . . . a drug-free treatment program which has grown over the years to include a variety of prevention and treatment services in both New York and California. We operate long-term residential programs and short-term outpatient programs. We work with adults, adolescents, and families. And we bring drug education courses into schools and drug information programs into communities.

I am grateful for the opportunity to testify today. And I think it is important for this committee to recognize first that drug abuse is very much a matter of perspective. How it looks depends upon where you stand. And the view you get in Washington is a grim one. Here, you are at the receiving end of those statistics that document the seemingly inexorable grip of drugs upon our society.

But there are places where the view is even more bleak. And they include many of our major cities. In New York alone, we have seen death by drug oversode rise by 20 percent between 1981 and 1983 . . . and the number of babies born addicted increase as much . . . while the incidence of drug-connected hepatitis rose by more than 50 percent. Drug-related crime has increased sharply, and nearly one-fourth of the homicides in the city are now drug-related.

And drug abuse looks pretty hopeless in many of the nation's schools . . . where the presence or prevalence of drug abusers makes education increasingly difficult to accomplish. It looks no better in our prisons or in our mental health facilities, where a growing number of patients are also drug abusers.

Yet there is one place where drug abuse does not appear hopeless. And that is in treatment programs—programs like Phoenix House—because we do not see people getting sick . . . or staying sick . . . or persisting in their sickness. What we see, every day, is people getting well. Not all of them and not all at once . . . but regularly, measurably, predictably.

We daily disprove the myth of drugs' invincible hold. And see instead the invincible spirit of former drug abusers who are breaking their drug habits . . . taking charge of their lives and returning to school, beginning careers, and starting families.

Now, with all we hear and see and read about drug abuse, it sometimes seems that the best-kept secret in the nation is the simple fact that drug abuse is curable. Treatment works. And it is not only effective, it is cost-effective to boot.

You will find, attached to my testimony, references to studies that document the kind of effectiveness treatment programs can demonstrate . . . studies sponsored by

the National Institute on Drug Abuse. The largest of these has shown that programs like Phoenix House . . . drug-free residential programs where the goal is abstinence . . . and where many drop out before completing a full 18 months or two years of treatment . . . still succeed with nearly half of all who enter.

Our own studies at Phoenix House use a harsher standard to discover how many of our residents achieve what we call a "best success." And that means they use no drugs, engage in no crime, and remain in school or employed.

We have found that nine out of ten graduates achieve a best success during the first year after treatment, and more than three-quarters are still "best successes" five years later. Even dropouts succeed—and those who stay for at least 12 months stand a 50 percent chance of a best success.

Now, the studies we have done have focused on long-term residential treatment. It is time-consuming therapy. But it is the most effective and the most cost-effective treatment for those drug abusers who are most costly to our society. And let me point our to the committee that these are the drug abusers most likely to be socially disadvantaged . . . most likely to engage in crime . . . and least likely to benefit from traditional mental health treatment. Their drug dependency is less often the result of emotional conflict than social impotence.

But these are not the only clients drug-free programs can help. Long-term residential treatment is not the sole method we employ. Our programs are both long-term and short . . . residential and outpatient . . . and designed for adolescents as well as adults. At Phoenix House, we even operate a special residential high school with the New York City Board of Education. It has a 140-acre rural campus, and it gives youngsters a second chance to make careers and move on to college.

We have learned, over the years, that the key to successful intervention or treatment is a variety of service programs and a careful assessment of client needs and strengths. We have learned that we can help just about any drug abuser. We can deal with all types and degrees of abuse and with all kinds of clients . . . as long as they are prepared to quit. And nobody can help those who are unprepared . . . who feel no pressure to change . . . no personal needs, no family demands, no fears of arrest or loss of employment.

What we have learned through treatment has made it possible for us to mount a drug education program that is reaching more than 35,000 school children in the New York City metropolitan area each year. We have started a similar program in California. And there is a California parallel to our intervention program for adolescents just beginning to abuse drugs . . . a program we have run in New York for several years now . . . one that demands therapeutic participation by the entire family.

We have been encouraged, from the outset, to develop new approaches . . . and to find new solutions to what was, when we began, an old and apparently unsolvable problem. And it took great courage on the part of public officials to turn to me and to my colleagues in the field . . . to look to nontraditional means when conventional medical methods failed.

And we have been fortunate . . . because New York City and New York State acted early and aggressively . . . because they invested in us and programs like ours . . . and in programs quite different from ours . . . and created a drug abuse service system that is unparalleled anywhere in the country or in the world.

Nor should we lose sight of the great role that has been played by the National Institute on Drug Abuse. It is their support and their research and their encouragement that has allowed the drug abuse field to develop in the ways that is has . . . and made routine and accessible that which was once experimental and rare. They have created a climate in which nontraditional approaches could rapidly prove their value and their legitimacy.

Let me point out to the committee that NIDA has only been able to do this because it has existed as an independent entity . . . free to set its own priorities. And it has been, in large measure, because of NIDA's support that so many inner-city neighborhoods and so many of the nation's socially disadvantaged are now served by programs based in their communities.

I feel that any threat to NIDA's independence is a threat to the kind of drug abuse services we have been creating these past 20 years—the kind that we have proven will work. And I do not believe that there is sufficient awareness of these methods and their effectiveness within the medical community today. Doctors simply do not know as much as they should about drugs.

And if you are seeking areas in which the federal government can display enlightened leadership, then this is surely one. It is inconceivable to me . . . for example . . . that many doctors qualifying today as prediatricians have no more than a cursory understanding of drug abuse . . . which is the major health problem of the ado-

lescents they will be serving. The result is that these doctors will rarely look for drug abuse. No matter how often they see it, they fail to find it—because they hardly ever consider drugs when formulating a diagnosis. They do not examine for it . . . or test for it . . . or look for indications in their patients' medical histories. And pediatricians are not alone. Other specialists are equally at fault. Internists and obstetricians, orthopedists and even psychiatrists often fail to spot the drug problems of their patients.

And here is where the federal government can help . . . by requiring more course work in drugs in our medical schools, by making this a condition of continued federal support for medical education.

But, turning closer to home, let me urge the committee to recognize the pivotal role of drug abuse treatment . . . to realize that there is no way we can confront drug abuse without adding to the heavy load already carried by treatment programs.

Certainly, greater efforts in prevention are needed. But prevention will not work unless there is a road back for youngsters who now abuse drugs. It will not work in schools where a prevalence of drug abusers determines student values. And, indeed, the first demonstrable effect of a successful prevention program is the identification of candidates for treatment.

Stricter law enforcement . . . as we learned in New York during the recent police "sweeps" . . . produces more demand for treatment than it does felony convictions. And that is what it should do. But the result, in New York City, has been to pack our treatment programs and put twelve hundred drug abusers on waiting lists.

The ultimate effectiveness of our efforts to confront drug abuse rests upon our capacity to treat and cure the individual drug abuser. Thus, our response to drugs can only be as strong as our treatment programs. And that is why I urge this committee to give first consideration to strengthening these programs.

In New York State, funds for treatment were reduced five years ago. Since then, government support has remained much the same. There has been no increase to cover costs that have mounted year by year. There has been no way to raise capacity to meet a growing demand . . . no way to afford more than bare bones care.

And yet, the Congress seems determined, in reauthorizing the ADMS Block Grants, to deny New York State additional drug abuse funds. Now, I realize that it is late in the game to talk about the reauthorization measures that are now in conference committee. Still, I believe that legislators concerned about drug abuse should recognize that the inclusion of set-asides and the shift towards a funding formula based primarily on population pose serious threats to existing treatment programs and are likely to draw drug abuse funds away from where they are most needed.

I will not argue that the proposed set-aside to expand treatment services for women is a bad idea, although I believe women are well-served by existing sexually-integrated programs. But I can see no benefit to a set-aside when additional funds are not guaranteed. That would mean New York programs, already underfunded and unable to meet present demands, might well receive less federal support than they do now.

The shift towards an ADMS funding formula based heavily upon population will pretty much ensure that no additional funds will come to many of the states where drug problems are most severe. Now, I do not know how alcohol and mental health problems are distributed, but I do know that drug abuse isn't evenly spread across the country. Drug abuse is contagious. It tends to cluster. Much of it clusters in California and Illinois and in New York. Indeed, state officials estimate that, if present trends continue, we will have more than 200 thousand heroin addicts in New York City alone by 1988 and half-a-million users of cocaine and other equally potent drugs.

In light of that, I do not see the logic of limiting funds for New York and other heavily hit states to increase the allocations for states which do not act the same size problem and which have done nowhere near as much to help themselves.

What I ask the committee to bear in mind is that treatment is the basis of any effective response to drug abuse; resources must be made available to strengthen treatment programs; additional resources cannot be denied to areas where drug problems are profound and supplied to areas where the need is less; a strong and independent NIDA remains essential to sustaining effective treatment capacity for the nation; greater understanding of drug abuse and drug treatment is needed by the medical profession, and the federal government should do all it can to encourage this.

Finally, let me warn the committee that we are well past the time when half-measures will suffice. The youngsters who began using drugs in high school have

grown up. They are parents. They are in the work place. They constitute, each year, a growing proportion of our population. So, each year now, the percentage of the nation at risk of drug abuse increases.

And each year the costs of drug abuse rise—the cost in crime and in social services . . . the costs to our education systems, our criminal justice systems, and our health care and mental health systems. Each year drugs cost our cities more . . . in declining public facilities . . . in "qualities of life" . . . in safety and security . . . jobs, taxes, and trade. And drugs are costing our industries too . . . in accidents and absenteeism, in morale and work quality.

Drug abuse becomes more costly each day. And the pity is that it is a problem we can beat. We know how to do it. We know how to cure it.

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STATEMENT OF KARST J. BESTEMAN, EXECUTIVE DIRECTOR, ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA

Mr. Chairman and Members of the Committee: I appreciate this opportunity to testify before the Select Committee regarding the strength and capacity of the drug abuse service system. As Executive Director of the Alcohol and Drug Problems Association of North America, I have access to our state authorities council, which represents the fifty states, an agency council made up of private non-profit, for profit, and public agencies and a council of individuals, which represents practitioners and professionals concerned with prevention, training and treatment in the alcohol and drug abuse field.

My own professional career has given me an opportunity to participate as a responsible federal manager and a close observer of federal, state and local programs. Today I would like to share with the Committee a deep concern I have that the treatment and prevention activities, built with such great effort during the 1970's, are in danger of being overwhelmed and are stressed beyond capacity.

The Select Committee has in prior studies documented the inadequacy of the fiscal support supplied through the block grant. The reduction of funding built into the consolidation of Alcohol, Drug Abuse and Mental Health block grant coupled with moderate inflation has taken a severe toll. A survey of members done by the National Association of State Drug and Alcohol Directors showed many states making the difficult decision to close treatment facilities due to lack of money. Patient demand for treatment was present. Community interest in having the treatment resources was present, but the erosion of funds was overriding these considerations. In that same survey each state was asked to look at what would be the use of a modest 10% increase. Many states referred to the restoration of diminished services and several spoke of treatment or prevention priorities especially with segments of the population such as women or adolescents.

In talking with independent or private program operators a similar theme emerges. Treatment demand is up. Drugs are more available. The purity is high and in some situations the price appears down. Add to this dismal picture the reports from the American Medical Association concerning the lethal abuse of prescription drugs and the scene becomes more ominous.

Finally as stressed and over committed as the drug service network is, it is not feeling the full impact of the demand for services. Many private alcohol treatment centers are treating people with substantial cocaine abuse problems. Additionally, members of Alcoholics Anonymous share freely with me that many of their newer members actually suffer from multiple abuses of drugs. Ten years ago in testimony before the Subcommittee of the Committee on Government Operations, I indicated

that "In the last several years there is no exclusive use of drugs: there is a mixture, we call it poly-drug abuse; the mixing of heroin, alcohol, barbiturates, et cetera. In blunt language, the consumer has become a garbage can of drugs rather than a connoisseur." The last decade has virtually institutionalized the behavior to the point of a popular weekly news magazine doing a cover spread on poly drug abuse.

There is within this grim review some good news. With the passage of the block grant, state plans and the continued establishment of a single state authority in drug abuse as required by the old Section 409 and formula grant were repealed, however, the states have continued to support and maintain their drug authorities. That state infra-structure is intact and ready to respond should the federal government renew its commitment to sustaining an adequate treatment network. Also with the mandated priorities as found in the H.R. 5602 the reauthorization of NIAAA, NIDA and the ADM Block Grant, the state agency will respond to newly imposed priorities.

The most damaging feature of the past block grant period has been the withdrawal of the federal government from policy and a leadership role. There were many and legitimate complaints as the service system was constructed with much federal direction. The transition from individual project grants via state-wide services contracts to state-wide services grants had addressed most problems. With the passage of the block grant ADAMHA withdrew from the consideration of service and prevention issues. By redefining its mission as narrowly research, it has removed itself from legitimate and needed federal functions. Specifically, it has abandoned its major informational and data gathering tasks by which congress and the executive branch could monitor trends in patient drug consumption and demographics and upon which strategic response actions were based. In the enforcement community such information would be called "intelligence." Today with our almost totally successful eradication of measles the Centers for Disease Control will report an "outbreak" of 18 cases in a high school or junior high. Today in a major city in this country a hundred or more drug abusers can present themselves for treatment with new combinations of drugs of choice and no one except the intake office at the local treatment center is the wiser. ADAMHA/NIDA used to regularly offer technical assistance or bring experts together to discuss troublesome or new problems being experienced throughout the country. Today, if the problem is unique to the service network it is dismissed as a state problem.

Historically, the federal government funded short term experiments which if successful were reported to the field and often recommended implementation by the project officers who communicated regularly with the state officials. Today such regular communication consists of written bulletins and an annual meeting. The sharing, mutual problem definition and solving has disappeared.

There are actions NIDA and the PHS can take to restore a measure of leadership. There needs to be a thoughtfully designed national priority agenda. This agenda should be based on goals mutually defined and accepted. The present system of federal goal setting does not incorporate sufficient, if any, consultation with non-federal persons to equitably represent the national concensus of the field.

A leadership role is available and needed in addressing new and experimental treatment techniques. Today we have an epidemic of cocaine abuse with patients entering drug abuse and alcohol abuse treatment programs across the country. When the country was faced with the opening influx of heroin addicts several publications by NIMH/NIDA detailed useful treatment techniques, therapuetic problems and gave sources of information. There is no comparable activity today. The private sector does provide training opportunities which are somewhat limited. Many private and public agencies do not have the money to send personnel for training due to travel and tutition costs. The need to have these skills increases as time goes by.

Leadership is to a great degree the ability to bring agreement on what course to set to meet the neds of the situation. it does not require direct management control. It does not require huge staffs. It does require accessibility and a willingness to engage the issues. It requires the courage to discuss strategy alternatives which are not immediately acceptable and the confidence to evaluate the pros and cons objectively. This is presently not happening.

There are also leadership opportunities in the prevention area as well. The Institute (NIDA) has rightly expanded its research into prevention programs during the last few years. With the block grant mandating a twenty percent expenditure for prevention, the research level at NIDA does not support the public policy decision of the congress and the administration. In testimony before both the House and Senate authorizing committees we have asked for language to encourage and insure greater efforts in this area.

Illicit drugs are on a continuum of substances people abuse. Evidence accumulates slowly as to the specific benefit of an explicitely targeted program. In spite of this handicap we know the precocious use of tobacco and alcohol statistically represents a much higher risk for later illicit drug use and abuse. The emphasis on healthy, life enchancing information and decisions clearly must start by the family before formal schooling and be re-inforced by the elementary school. Decisions regarding tobacco do occur in the fourth, fifth and sixth grade. We know all too often so do decisions on alcohol and marijuana.

There are attitudinal changes occuring in the age groups of greatest risk. The idea that some drugs are harmless and do not pose a hazard to health is passing. Youth and parents are recognizing that there is an element of danger in "casual" or experimental use and that the danger is much greater than perceived ten years ago. The concept of abstinance from drugs and alcohol are both enjoying a return to respectability. The attitudinal changes reported by Dr. Lloyd Johnston on the high school senior population are important trend indicators. Regretably, the young people most at risk to succumb to drug abuse and addiction fail to reach their senior year in high school and are not part of the survey.

The needs of the field can be summarized rather briefly. Meeting these needs is much more complex and time consuming. First, the demand for treatment, training and prevention services exceed the combined state and federal resources presently allocated. Therefore, the capacity of the treatment system has reduced. The clear policy question asks "Are drug treatment services a justifiable priority and an effective expenditure in a time of budget restraints?" Treatment outcome studies of the last decade demonstrate the answer should be yes. In our opinion there should be a level of service, similar to the number of treatment slots, to which the federal government is firmly committed.

Second, the federal government must give support and leadership in defining adequate treatment services and evaluating new treatment techniques. This information must then be quickly disseminated to the field with supporting technical assistance.

Third, the federal government must restore its information systems to give substance to policy decisions and to guide strategic planning. For example, if there is a sudden decrease in patients presenting themselves for admission with heroin addiction, decisions on investments in therapuetic drugs being developed for heroin addiction would need review. The role of methadone might be changed. We know there are narcotic-antagoinists. Should NIDA be looking more aggressively for a cocaine antagonist? The data to guide these answers is now anecdotal.

Fourth, the federal government must increase its services research activities. There are emerging and well defined patient sub-groupings: women, adolescents, ethnic and racial minorities. Much of our treatment lacks specific response to these sub-groupings' unique needs. Differential diagnosis and assignment to uniquely structured treatment modalities is still an imprecise art. NIDA has made an attempt to clarify the issues in an earlier study. Efforts in this area must be continued.

Fifth, policy development and issue clarification must be opened to greater participation by persons facing the day to day problems. The field now enjoys the strength of having experienced state and local experts capable and willing to test the usefulness of developing policy early in discussion. This resource should not be ignored. The last fully consultative attempt at policy development and discussion was the white paper of 1975 produced under the Domestic Council. Subsequently, each formal statement of federal policy has had less testing of concepts by people directly responsible for the implementation.

Finally, we are in an era of Prevention. It is a stated priority in the Public Health Service. The Office of Drug Abuse Policy in the White House supports the concept of Prevention. The block grant mandates activity and expenditures in prevention. There is no priority in information, materials, technical assistance and research which reflects the rhetoric. Expenditures have remained constant or reduced in all categories except research and it has not managed any significant real growth.

In closing, I want to share a serious concern I have. At great expense, expenditures of human energy, and with much difficulty this country put together a public and private program response to a serious national problem; drug abuse. It took almost eight years to mold and build. We are in danger of permitting this useful and effective effort to be eroded into disarray by neglect and non-support. The drug abuse problem has not gone away. People may have tired of it but it is still a reality of every major city and many smaller communities. The inattention, possible neglect, which the federal government has displayed must be reversed. Failure to do so will result in the need to expend much greater sums in a few years as the prob-

lems becomes worse. It can then again qualify for the label of the "No 1 domestic priority." I urge this Committee to educate their colleagues regarding this danger.

Thank you for the opportunity to share some thoughts about the state of the field. I would be pleased to answer any questions you might have.

ATTACHMENT A

These responses were provided to NASADAD which requested imformation on the level of demand for prevention and treatment services, the reasons for any increase or decrease in service demand and a description of how the State has absorbed the Federal reduction in funds which accompanied the arrival of the ADMS Block Grant.

ARIZONA (DRUG ONLY)

Pressures for increased programming in methadone treatment clinics and residential treatment facilities have led to waiting lists. In particular, demand for methadone related treatment has created a waiting list condition at most facilities in Phoeniz. Two state supported facilities in Phoenix have a waiting list, as of this writing, of 115 clients. No additional resources have been acquired this year either from the federal or state governments to augment programming. Programs in Tucson are experiencing similar demands for residential and methadone treatment capacity.

Arizona is one of the most rapidly growing states in the nation and part of the rise in demand is associated with this rapid growth. In addition, many arrive in Arizona with no support and only a speculative chance at a job. These people and the families that are dependent on them will likely experience economic and social pressures and may turn to drugs. Therefore, the increased migration plus the unstable conditions they move into heightens the chance of drug abuse. Treatment statistics for the first half of FY 84 as compared to FY 83 suggest a 2 percent rise in opiate related registrations and a 4 percent rise in cocaine registrations. Enrollments for marijuana usage is up somewhat—6,410 people will be treated by years end.

The number of registered clients served from FY 80–FY 83 had grown as follows: FY 80 (5,378); FY 81 (5,430); FY 82 (5,574); FY 83 (6,193); FY 84 (projected at 6,410). Successful management of the categorical grants and overlapping block funds plus economizing through various efficiency strategies on the part of contracts has lead to expansion without increased financial support. However, in FY 84 the Department of Health Services decided to spend all of the expected FY 84 block in one state fiscal year. That means next year less funds will be available than needed to simply maintain programs at state FY 84 funding levels. It is not likely we will achieve maintenance budgeting even using state FY 83 funding levels. It is not likely we will achieve maintenance budgeting even using state FY 83 as the base year. State appropriation discussions currently suggest no chance for any increases in state appropriations to offset the lack of sufficient block funds in FY 85.

What is needed is significant increases in FY 85 block appropriations and no change in funding formula. Arizona state appropriations have always formed at least half of all funds contracted for drug treatment an prevention. Categorical grants were sizable particularly because legislative interest and funding for drug abuse. Any formula other than the current one penalizes Arizona for many years of serious participation in treatment delivery by raising meaningful sums of local dollars

ARKANSAS

Demand for treatment and prevention services has increased due to:

Expanded contact with a wided variety of individuals, organizations and groups by the agency;

Recently enacted stiffer DWI penalties; and

Increased efforts in the area of expanded viability by the OADAP regarding increased public awareness activities and great expansion in the use of volunteers. Also many Chemical People groups remain functional.

To date, treatment needs are being met. The majority of all funded programs are operating at or beyond funded levels of service. Requests for non-treatment funds and services have increased the most dramatically. The increase has not subsided and shows no signs of doing this. Early intervention, primary prevention, and education levels of service have increased over the year. Requests for information and funds for Channel One types of programs are almost exceeding available resources. To date, demand is being met in these areas. Another consideration is the recently

developed education standards package and the forming of a Governor's Task Force on Alcohol and Drug Education. Any sort of report from this group will place additional demands on limited resources.

Reductions in funding accompanying the ADMS Block Grant resulted in a $1.3 million or 37 percent reduction in alcohol treatment funds and a $170,000 or 19 percent reduction in drug treatment funds. Remaining funds were allocated on a per capita basis and stringent administrative and service reimbursement levels were set.

CALIFORNIA

The State agency has assessed that there is an unmet need in the area of prevention and is working towards meeting that need by placing further emphasis on prevention (the State has contracted with a California parents group to attempt to address the unmet need). In terms of treatment, there is also an awareness in the State of an increased need for treatment services. The Governor has proposed an additional $5 million to the counties to spend as each individual county feels it is most needed.

State savings from a variety of sources (e.g., contract savings) were used to cover Federal reductions on the drug side; the alcohol side is not experiencing any problems.

CONNECTICUT

Demand for treatment and prevention services has increased due to:

The Governor's Task Force on DWI; a new law supporting further referrals to treatment after completing DWI courses; intensified enforcement of DWI legislation; increased public awareness of DWI issues; publicity and CADAC effort associated with Chemical People; Governor's Task Force on the Homeless; national and statewide publicity on the homeless alcoholic; expanded use of cocaine; and increased services for the elderly (HFCA demonstration project).

In the current fiscal year there has not been an increase in resources that matches the increased demand for services. The major effort has been to maintain the present funding levels which have been harmed by the decrease in federal funds. The consequences are: a continual waiting list for methadone maintenance; homeless alcoholics are daily turned away from shelters; funds to support community based alcohol/drug task forces is not available; peer counseling programs for youth are not funded.

Reductions in funding accompanying ADMS Block Grant had the following impact:

The Connecticut Alcohol and Drug Abuse Commission (CADAC) lost 24 percent of its funded positions.

A Long Term Care Facility for the chronic alcoholic with an anticipated 600 yearly admissions was not developed.

Methadone Maintenance Programs continued to have a waiting list of 190 individuals.

Shelters for the homeless alcoholic with a current 37,000 client served are unable to meet demands for more services.

Prevention: lack of funding made it impossible to develop a Peer Educator/Counselor Program that would impact 30 schools, 60 adult advisors, 480–600 students trained and 36,000–48,000 students reached through trained peer counselors.

Approximately 45 community drug and alcohol task forces did not receive funds for such projects as awareness fairs, established hotlines, sponsorship of saferides, effective-parenting courses, etc.

CADAC could not allocate new monies to high priority target group projects/programs for women, and youth and minorities.

DELAWARE

Service demand has risen because of:

Increased utilization of Methadone Maintenance programs apparently due to fluctuation in heroin supplies. Overwhelming increase in intoxicated driver program due to intensified enforcement of DUI laws. Increased utilization of alcohol residential programs due to increased public awareness/confidence in program. Prevention funding freeze instituted in FY 1984.

There are currently extensive waiting lists in DUI programs. A waiting period for residential programs. No increase in state funds has offset federal reductions.

Delaware has attempted to increase the productivity of services providers by completely revising its service delivery and funding mechanisms. While these revisions have resulted in consolidation of services, they were accomplished at the expense of a number of local programs previously funded. Two programs no longer receive our support. A freeze on prevention funds was instituted in FY 1984. While some of the changes made have been positive ones we have been unable to expand services to meet the increased demands referred to above.

FLORIDA (ALCOHOL ONLY)

There has been an increase in the demand for alcohol treatment and prevention services due to the following: increased public awareness, a tremendous population growth, increased sanction of DWI offenders (the arrest rate increased by 85 percent in a one year period). There is now a bill pending in the State House of Representatives which would reduce the BAC from .1 to .05.

The State agency is hurting for resources. The reduction of Federal support for alcohol and drug services has had a devastating impact particularly at the community level. The State has attempted to soften the impact of the Federal reductions through the provision of an increase in State funds.

FLORIDA (DRUG ONLY)

There has been an increase in the demand for services because of increased public awareness, a closer relationship between the criminal justice and treatment systems, and an increase in Statewide TASC referrals (about 70 percent). Also, although in Florida there has been more emphasis on the supply side issue, the availability of illegal drugs still remains high.

There has been an increase in resources through State funded programming, however, it has not met the full need or the demand for more services. Currently programs in Florida are operating at 110 percent capacity.

The impact of the 42 percent reduction in Federal funds could have been devastating in Florida, however, the State legislature has picked up the difference, and so there was no loss of programming. The State has been fortunate in the fact that the Governor and the legislature are very sympathetic to the drug problem in Florida. Without their support the reduction could have meant catastrophe for Florida.

GEORGIA

Service demand has risen because of DWI enforcement, increased evaluation and mandated treatment. Also, the increase is related to an increased availability and abuse of cocaine.

Because of a lack of resources, courts have had to omit evaluation and treatment. There is a greater emphasis on information and referral services, self-help groups and on serving the most disabled, whether or not appropriate.

Federal funding cuts have resulted in:

Sharp reduction in prevention and training activities;

Much more emphasis on serving the more disabled, less amenable to treatment client;

Restricted outreach and early identification/intervention activities; and

Limited availability to evaluate and provide services to criminal justice system clients.

Also, while no "programs" have closed, services have become less available and accessible by centralization of services in major population areas, closing or sharp curtailment of satellite centers. The number of clients served has remained constant, however, the number and intensity of services provided have decreased. The number of recidivists has increased, and services like family treatment and education have decreased (despite the 20 percent requirement). The number of direct service staff has decreased and some counselors have caseloads that have increased to over 100 at a time.

ILLINOIS (DRUG ONLY)

There has been an increase in demand for treatment services for two significant reasons:

There has been a substantial increase in clients seeking treatment for cocaine abuse. Particularly in Chicago there is an enormous availability of the drug.

The number of clients seeking treatment for heroin has increased tremendously. This has occurred because the street quality and purity of the drug increased about

two years ago. In FY 1984 there were more admissions for heroin abuse in Illinois than there had been since 1976.

Since sufficient resources are not available to appropriately handle the increase in demand for service, clients have been placed on waiting lists. A large number of these people are clients in jail waiting for treatment. In many respects placing someone on a waiting list has the same effect as turning them away.

As a result of the 42 percent Federal reduction both the drug and alcohol agencies in Illinois have suffered substantial staffing cuts and had to eliminate the provision of some field services (e.g., program monitoring). This was done in order to avoid substantial cuts in community programming. Although there have not been any substantial cuts in community programming the State agency has been unable to grant increases to programs in several years.

IOWA

There has been an increase in the demand for treatment services because of increased public awareness and intensified enforcement of intoxicated driver laws. Also, the courts are sending DWI offenders to programs for assessment more often now as opposed to placing them in jail.

Sufficient resources are unavailable to meet this increased demand as evidenced in the fact that all urban centers have waiting lists of at least three weeks (even urban centers with a population of 30,000).

The impact of the 42 percent Federal reduction has resulted in increased client loads and a high rate of counselor burn-out (the salary of counselors in some places is only $12,500).

KENTUCKY

The increase in demand for services in Kentucky is due to several reasons. Among them are: more adolescents are seeking outpatients services due to changes in school policies; more adults are being screened through court programs and referred to treatment; more families are seeking outpatient services to deal with co-alcoholic issues; and more programs are being established in hospitals and private practice (these programs often generate referrals to public programs).

At the present time, urban outpatient and residential programs are at capacity and have waiting lists in place. The 11 rural residential programs report an average 72% utilization with 44 persons on waiting lists. Transportation in the rural areas seems to be a major problem.

Since the cuts in federal funds, the following programs have closed:

5 Rural prevention projects focused on youth. (Murray, Owensboro, Morehead, Georgetown, and Frankfort)

4 Urban prevention projects focused on other special populations. (Alcohol Community of Louisville, Alternatives for Women-Louisville, Lexington Black, and Lexington Elderly)

12 Halfway house (4 urban, 8 rural). (Hopkinsville, Owensboro, Henderson, Louisville, Morehead, Hazard, Lexington (3), Richmond, Winchester, and Danville)

1 Residential treatment program (rural). (Limestone Recovery, Maysville)

6 Detoxification units: (Dayton, Middlesboro, Corbin, Columbia, Lancaster, and Frankfort)

4 Rural occupational early intervention programs. (Campton, Corbin, Elizabethtown, and Maysville)

2 Outpatient projects (1 urban, 1 Rural). (Louisville Metro and Owensboro Aftercare)

1 Adolescent Residential Treatment Program. (Adena, Lexington)

Single State Authority Central Office personnel has been cut half (from 28 to 14).

LOUISIANA

Increased demand for services are due to:

Passage of new and tougher DWI legislation coupled with intensified enforcement of the DWI laws;

New private providers are continuing to open and operate treatment programs for both inpatient and outpatient;

Increased education and prevention activities have materially increased the demand for services particularly in educational environs; and

Public awareness of the problems associated with alcoholism and drug abuse has also escalated the demand for services.

The demands for service outstrip the state's ability to provide the necessary services. Clients are placed on waiting lists awaiting placement in appropriate treatment programs. There are insufficient resources to meet the needs for service. Resources refer to dollar, physical facilities and treatment personnel.

Since Louisiana started receiving ADAMHA block grant funding three drug treatment and one alcoholism treatment programs have closed. Due to declining revenues in terms of real dollars on both the state and federal level the treatment facilities remaining are overtaxed and have reached a saturation point. The drug programs which were closed had a total caseload of 451 clients and the alcoholism program had a caseload of 204 clients. The closure of these programs has caused the transfer of clients into other programs which are already operating at peak capacity. Programs are saturated and operating with a patient to counselor ratio which almost precludes success in treatment. Group therapy is becoming a necessity as individual counseling sessions are a luxury which can not be scheduled. Therapist burnout and employee turnover are increasing at an alarming rate.

MARYLAND

Maryland is still under the influence of an over-abundance of heroin and an ever-increasing supply of cocaine. Also evident within the last years in Maryland is a major increase among young people of the use of PCP.

We have not been able to obtain sufficient resources to keep up with the demand. We have officially created 360 new treatment slots by increasing the client/counselor ratio from 25:1 to 30:1 but we presently have a waiting list which approximates 13 percent of our people in treatment, and the present time between application and admission to treatment is 47.2 days.

In Maryland, we have been fortunate in the State Government replacing the majority of lost funds but this merely means we are operating practically at the same level of 1980–81. The money which has been used to replace federal dollars would have been added to our budget anyway so that had the federal funds remained level, the State would have made up inflationary costs and program improvement.

MASSACHUSETTS (ALCOHOL ONLY)

There is significant increased demand for youth residential treatment programs, need for Hispanic bilingual bicultural half-way houses; increased programs of Fetal Alcohol Syndrome; and stronger drunk driving laws coupled with provisions for more intensive treatment of offenders as conditions of probation. The latter has significantly increased demand for outpatient programs and confined inpatient treatment.

We have only one youth residential program for 16 beds. We get 40 calls a week and could create a 2 year waiting list. The state is level funding us in FY 84 and FY 85 and we are unable to develop new initiatives.

Even though federal funding decreased, we did not have to decrease services because we had federal carryover funds from the formula grant and some state fund increases. However, this is coming to an end after 3 years. Level funding from the Feds and the State will result in no new initiatives to meet increased demand and a gradual reduction of service unit.

MICHIGAN

Increased public awareness of substance abuse problems has resulted in an increasing demand for services. Extensive media coverage of drunk driving problems (particularly in reference to the changes in Michigan's statute which took effect April 1, 1983) has continued with current focus on whether "check lanes" might be implemented. Overall, drunk driving arrests are increasing.

The national "Chemical People" campaign also stimulated a great deal of local interest; many concerned citizens groups are continuing with this effort.

The ongoing economic difficulties in Michigan continue to bring people into services; it is fully expected that substance abuse problems caused or exacerbated by the economic situation will continue to surface over the next several years.

Interest in treatment of adolescents has recently resulted in introduction of legislation which would encourage mandatory inpatient or residential treatment which could include "protective custody" for 72 hours or longer.

Generally, widespread availability of a variety of prescription drugs (especially certain Schedule 2 drugs) as well as an apparent increase in supply and purity of heroin and cocaine will most likely result in maintaining or expanding service "demand."

At the time that budget reductions began to be necessary (FY 1979/80) the substance abuse network was serving about 85,000 admissions on an annual basis. Since that time the level of admissions have remained about 10,000 fewer in each of the last three fiscal yers. Although some adjustments in funding sources have allowed the network to remain essentially intact, it is clear that the network has ben unable to return to capacity such that prior service demand levels (e.g., 85,000 plus) can be met.

The federal block grant reductions have been somewhat offset by increases in third party fee collections. However, the proportion of admissions that are unemployed has steadily increased to 60 percent of all admissions. Third-party insurance coverage is not potential payment resource for many admissions.

Utilization rate of all service categories increased in FY 1982/83 over the prior year in efforts to meet client needs and services demand.

Waiting lists have been necessary in some treatment programs. Even with the establishment of waiting lists, there are indications that treatment admissions in some areas of the state are increasing over the same period of last fiscal year; in southeast Michigan there is an 8 percent increase in treatment admissions for the first four months of the FY 1983/84 period over the same period in FY 1982/83. The number of screenings has also doubled over last year; mostly this is due to drunk driving assessments.

MINNESOTA

Lack of treatment resources has primarily affected non-insured and public assistance clients. Services for these clients have been affected by the reduction of ADMS Block Grant funds, changes in federal and state entitlement programs (such as Medical Assistance), cut-back or hold-the-line budgets for Title XX and State aids to local governments, decreased local tax revenues due to poor economic conditions, and ratable reductions or prospective payment systems for certain programs.

Minnesota's State Hospital CD treatment programs now have waiting lists for admission. At the same time the number of clients receiving services through Title XIX, Minnesota General Assistance Medical Care and county funding has decreased significantly; clients receiving CD services through those services decreased by approximately 30 percent from 1981 to 1982.

Changes in Minnesota's Driving While Intoxicated laws and increased public awareness of the problem have resulted in an increase in DWI arrests from a rate of 50 per 10,000 persons in 1979 to a rate of 85 per 10,000 persons in 1982. Public awareness of chemical abuse problems in general has also increased due in part to efforts such as Chemical People-Minnesota. The Chemical People project produced a significant increase in requests for prevention materials and programs.

Results of the reduction of Federal support for chemical dependency services in Minnesota include:

The cancellation of funding for five drug treatment programs, the cancellation of funding for four previously direct-funded programs, a reduction in funding for other treatment and prevention programs and the elimination of funding to counties for detoxification transportation.

If FY 1985 funding were restored to FY 1980 levels (with an inflationary increase) additional funds to Minnesota would be approximately $2,000,000. Examples of the activities which could be funded include:

(1) Restoration of detoxification transportation funding at $300,000, providing transportation for 6,000 clients. Transportation to detox is a significant problems for rural law enforcement officials.

(2) Outpatient treatment services for persons with no other source of payments. The cost of outpatient treatment averages $1,400 per client. An allocation of $900,000 in this area would provide treatment for 650 clients. $2,000,000 would provide funding for 665 clients.

MISSOURI

Increased demand for services has resulted from changes in the DWI legislation which requires offenders to complete DWI programs for reinstatement of the drivers license and increased public awareness resulting from media campaigns such as "Chemical People".

We have been unable to obtain sufficient resources to meet the increased demand, as evidenced by the fact that our statewide waiting list for services increased from 195 on July 1, 1983, to 390 in February of 198[illegible].

The impact of the federal reductions are as follows:

Central office administrative staff decreased from 52 positions to 34.

Community based vendor agency budgets were reduced initially by 30 percent. The following year budgets were increased by 15 percent, but have maintained for the past three years at approximately 85 percent of the initial level. No programs were closed as the result of the reduction.

MONTANA

Demand for services have increased due to: Increased Public Awareness; intensified Law Enforcement (DWI); and more health insurance coverage allowing more people to seek treatment.

There are, however, not sufficient resources to meet the treatment needs of the indigent population, particularly inpatient treatment. Clients are being turned away and placed on waiting lists in publicly funded programs.

Since 1980 the Montana State Agency (Alcohol and Drug Abuse Division/Department of Institutions) has reduced its staff by approximately 38 percent mainly in the areas funded by categorical grants for prevention, education and training services. These services have been reduced substantially and maintained by existing staff, block grant and state funds.

From 1980 until 1984 publicly funded treatment programs have had to remain at current levels of services each year. The state and local publicly funded programs have been unable to expand services or develop new needed services. Caseloads and clients served have remained constant while utilization rates and waiting lists have increased and length of stay has decreased. No major impact has occurred since 1980 and programs have been able to maintain current levels with the reduction of federal funds because of the following: Categorical grant funds did not run out until the end of the first block grant year; legislature did not appropriate all block grant funds to increase services; and categorical grant projects were not continued with block grant funds. However, by 1986 we estimate a reduction of services will have to take place if the present funding remains constant. State alcohol and drug funds generated from taxes on the sale of alcoholic beverages leveled off in 1984 and is projected to decrease in 1985. Present publicly funded programs will have to generate additional revenues (i.e., third party pay or client fees) to maintain current level of services.

NEVADA

The increased demand for service in Nevada centers on residential alcohol beds and DUI related services. The demand for residential alcohol beds has increased because more clients are reveiving CPC and Detox services. The demand for DUI services has increased due to increased public awareness and stricter legislation.

Our resources have remained generally constant and have not allowed for expansion of residential alcohol beds. DUI services have kept pace with increased demand because the resources for DUI services are generated from clients under court order to attend and pay for DUI school.

In addition to the reduction of Federal support, our State general fund support decreased 22% in FY 83-84. The effects of Federal and State cuts have not been fully felt because we have been able to maintain constant funding levels by utilizing block grant forward funding. The block grant forward funding will be spent out by FY 86. At that time we will have a minimum deficit of $750,000. This is approximately 25% of the amount we currently have available for treatment and prevention.

NEW JERSEY (DRUG ONLY)

The reason for the increased demand for drug services are:

New Juvenile Justice Code (1/1/84) and new Family Court System calls for more referrals to community treatment;

Increased demand for cocaine treatment;

Increased awareness because of media attention; and

Continued high demand for heroin treatment services.

Because of fiscal constraints and cut of $4.2 million federal monies, the daily client treatment load has been reduced. Also, monies were diverted from treatment, to comply with the 20 percent prevention mandate of the Block Grant. Clients have been turned away and placed on waiting lists.

Specific impact of the Federl reductions in support include:

Daily client treatment loand has been reduced from 8,000 to 6,100;

Client fees increased, and because of the lack of Medicaid coverage, indigent clients are charged fees;

Counselor caseloads have increased from a ratio of 1 to 35 to 1 to 50 and more;
Almost all programs have a utilization rate of at least 100 percent. A large number of programs are at 120 percent and beyond; and
Patients are being turned away from treatment services.

NORTH CAROLINA

Demand for treatment and prevention services has remained stable. However, if additional state or federal appropriations are not forthcoming during FY 1984-85 alcohol and drug abuse programs in North Carolina will experience an approximately 20 percent decrease in funding due to the fact that "carry over" block grant funds will have expended by close FY 1983-84.

NORTH DAKOTA

We have experience a 300 percent increase in addiction evaluations as a results of (a) public awareness (b) North Dakota DWI Law. We have experienced a 60-75 percent increase in requests for addiction treatment services. Services to family members have increased approximately by 30 percent.

About 30 percent of those requesting services withdraw their request due to waiting period of 3 to 5 weeks. We have had only a 10 percent staff increase.

No programs have been closed or counselors reduced. Low and uninc eased salaries and working conditions have forced many senior counselors to leave public employment. Thus, the overall quality of our treatment staff has diminished significantly. We have not kept up with the demands for services.

Waiting lists, overcrowded case calendars and treatment groups, inexperienced counselors (some without benefit of close supervision by experienced staff) have all contributed to reduced treatment quality. No objective measurements are available for this.

OHIO (DRUG ONLY)

Demand for treatment and prevention services has risen due to increased public awareness of drug and alcohol abuse, especially through the Governor's office, the Ohio Recovery Council and local prevention efforts. Increased involvement in schools in the area of substance abuse. Continued high unemployment through-out the State. Increase substance abuse detection. Treatment and diversion services in both the adult and juvenile criminal justice system. Greater employee assistance programming. Better identification of populations needing substance abuse services. Intensified enforcement of DUI laws.

For the state agency, there has been a reduction in staffing. Although for service providers the reduction in Block Grant funds was spread over three years, the overall impacts of the reduction are as follows:

(*a*) Clients without resources to cover the cost of treatment, especially residential services, do not have the access that they once had because programs focused more on serving clients with resources to cover treatment costs.
(*b*) There were reductions in the length of treatment.
(*c*) Elimination of extensive client follow-up activities.
(*e*) Increase in the use of group therapy; decrease in the use of individual therapy.
(*f*) Not filling staff vacancies.
(*g*) Increase caseloads for staff.
(*h*) Consolidation of programs, especialy in rural areas.
(*i*) Increased competition among service providers for available dollars.
(*j*) Putting clients on waiting lists,
(*k*) Programs are depleting their operating reserves.
(*l*) Lack of programs expansions to meet needs of various special populations (minorities, sensory and motor impaired, Vietnam Veteran, etc.) with substance abuse problems.

Although other sources of funds have been secured for the provision of substance abuse services, these funds have been sufficient to keep up with the demands for services. consequently, the following were implemented by programs: clients were put on waiting lists; the length of treatment, especially in many residential programs, was reduced.

OREGON

Reasons for increased demand for services include public awareness, increased awareness of counselors in allied services (such as vocational and childrens services), increased enforcement of DUII statutes, increased need by the courts for sentencing

alternatives, earlier indentification (through DUII evaluations) of individuals needing treatment rather than referral to education services and to emphasis on deinstitutionalization of individuals from state correctional and hospital facilities. State institutions simply can't afford the level of service per individual, or serve the number of individuals they previously could. This puts pressure on probation and parole, which in turn puts pressure on local treatment programs.

Sufficient resources have not been available to meet increased demand. Local treatment programs have been under such pressure to accept client referrals from both law enforcement and criminal justice sources that the programs have had to add these referrals to existing workloads . . . rather than employ waiting lists. All of our service modalities are running at or close to 100 percent utilization except outpatient alcohol and outpatient drug free which are running at 170 percent and 125 percent respectively.

The federal participation was not *just* reduced by some percentage. After the reduction in total funds coming to a state (in block form) it was then required that 20 percent be set aside (from treatment) for use in prevention and early intervention services. While such services are needed and important, a state had to reduce treatment service funding even further in order to comply. Next, minimum funding percentage requirements were established without regard to any particular state's circumstances; thus, in Oregon, where the ratio of primary alcohol problems to primary drug problems is approximately 5:1, the 35 percent minimum for drug programs created an artificial overabundance of block funding for drug abuse and a corresponding underabundance for alcohol abuse. Additionally, clinical training funds, which were very important to assuring therapists who have diverse backgrounds (recovering, minorities, etc.) in this field, were eliminated and, long range, will have a very negative result.

Beyond the block grant, federal participation in all the related kinds of services that alcohol and drug abuse treatment programs rely on was also reduced. Across the horizontal plane, at the federal level, cuts were effected, and policies were changed, in essential vocational educational mental health, housing, . . . programs. What came down to the state level then was not just a cut in treatment program capacity, but a cut in the whole range of services that make up competent individual treatment plans and that allow individual clients to "keep going" while participating in treatment.

This "range of reductions" descended on down to the local level (the service level) and was promptly made more drastic by the rapidly declining ability of county and city governments to maintain their previous levels of financial participation (let alone compensate for federal cuts). It was a good example of the economic concept of the "multiplier effect"—but in reverse. It's effect on service programs was a contraction far greater in size than federal block cuts alone. It has been perpetuated since then by the threat of drastic property tax relief initiatives, thus, even where a few local governments could help with some of the problems, they have been reluctant to do so.

An additional effect on local programs has been an increase in the number of indifferent or partially indigent clients, thus client fees as a source of revenue of programs has declined.

Programs in Oregon have not closed, nor have they reduced the number of clients they are attempting to serve—it is the reverse: they are serving more people in total and per counselor. But again this choice was not entirely voluntary due to the pressing need to support other critical service systems relating, for example to youth, offenders and so on. The price that's being paid is in counselor stress and service effectiveness. Alcohol and drug abuse services can be stretched so far so long. The interesting thing to see will be how many other critical service systems collapse if treatment finally burns out. The interdependence will be evident—more than is realized.

PENNSYLVANIA

The past few years have produced a leap in Pennsylvania's depth and breadth of understanding and sensitivity to the implications of alcohol and drug abuse. Pennsylvanians are aware, as never before, of the price that society, communities, institutions, families and individuals pay for drug and alcohol abuse. DUI laws, the Chemical People project, which had its origins in Pennsylvania, the cocaine epidemic, health insurance realizations of costs attributable to drug and alcohol, etc., have all been responses to this understanding.

At a time when the drug and alcohol system is implementing strategic to offset federal cutbacks, public interest, in dealing with drug and alcohol abuse is at an all

time high in Pennsylvania. Effective and successful prevention, education and intervention programs simply create a higher level of treatment demand. A 40 percent cut in federal treatment support over three years has resulted in the decreased ability of our system to respond to the increased demand for services and to the "newly" unemployed that have lost insurance coverage in Pennsylvania. Waiting lists for residential and hospital treatment have gotten larger and thousands of Pennsylvanians have been turned away from needed outpatient and residential services. Space is available in facilities but "free space" is not available.

Pennsylvania is very fortune that the Governor and legislature have been supportive of the drug and alcohol system over the past three years with over $3.0 million of increased state support. However, this alone, cannot offset the $5.5 million loss in Federal treatment alone, to say nothing of inflation and other increased costs over the past three years. Over 30 drug and alcohol agencies in Pennsylvania have closed over the past two years. Many of them were reliant on federal funds. The demand for their services was high, but the inability of the public sector to underwrite the cost of services contributed to their demise. The thirty are a mix of inpatient hospital, outpatient, shelter and residential programs located primarily in urban areas. ODAP estimates that between 8,000 and 10,000 Pennsylvanians will be refused care for lack of public support in State Fiscal Year 1984/85. Large increases in admissions and caseloads are not realistic at this point, given current funding levels, since our productivity and performance measures indicate a system that is close to a utilization, saturation point. There are certain residential programs where demand for services is historically high, but empty beds exist for lack of public support. The system needs a significant infusion of restored federal funds to deal with the uninsured and youth being referred for treatment as a result of prevention initiatives. Philadelphia and Pittsburgh, in particular, have been acutely impacted as a result of the federal cuts.

Pennsylvania has put on line 20 percent of its Block for prevention/intervention efforts. These efforts are needed and successful. However, the redistribution of $2.2 million treatment block funds to Prevention/Intervention had the net effect of developing one side of our system to the detriment of another. The cuts plus the redistribution within the Block have created Pennsylvania's treatment dilemma.

PUERTO RICO

Demand for services has increased because of a greatly heightened awareness of alcohol and drug problems among both citizenry and private sector; sharp increases in use of Puerto Rico as an intermediate stop on South American drug routes, e.g.: average 3.2 crafts confiscated weekly, either air or sea, often already unloaded and heavy emphasis on legal drug manufacture and beverage alcohol production, increasing annually.

Clients are never refused treatment, but there are now only 30+ drug beds for a population of 3.5 million. Waiting lists for evaluation are often three-four weeks, and for entry sometimes up to six weeks. Also, there are literally no private hospital or drug beds in Puerto Rico, they not being conditions deemed eligible for insurance reimbursement. However, some emergency treatment is given in State and Municipal hospitals.

As ADAMHA funding has decreased, the Commonwealth (State) has attempted to replace those funds with State revenue dollars. This replacement has resulted in level funding only, without an increase for COL adjustment or inflation.

A series of alcohol, drug, prevention and criminal and juvenile justice centers have closed, and their services consolidated into other area centers. The net results are increased caseload, less accessibility to treatment or intervention, clients who cannot avail themselves of ambulatory services because of transportation difficulties, occasional shortages of routine medication, physicians forced to cover more than one facility or cut their hours, and many others. The increased emphasis on ambulatory or out-patient services has substantially increased the rate of recidivism in all areas.

SOUTH CAROLINA

Comparing first six months of FY 83 with first six months of FY 82 shows a 7.4 percent increase in clients and a 13.4 percent in number of service hours. Contributing factors include increased public awareness of the problem; new Driving Under The Influence Law.

Treatment caseloads have increased and funds to employ sufficient staff to handle this increase are not available. The capability of the system to absorb new clients has reached its peak. In prevention, while there has been increased revenues, there

is still a serious deficiency due to resource shortage. Printed material, once provided by clearinghouses is a critical need. Also, resources for programs in the schools are needed.

Available beds in detoxification centers have decreased by 24 percent and days of service have declined by 42.5 percent; and existing centers have been forced to place greater emphasis on client fees, utilization has suffered because of more stringent readmission requirements for clients who did not pay for earlier admission and still had an outstanding debt to the center.

Halfway house beds have declined by 27.6 percent and days of service have dropped by 25.7 percent.

Two residential drug treatment centers with a total of sixty beds have been closed.

Outpatient clients and hours of service have climbed steadily as the system has improved its efficiency but we have now reached the point of overload.

TEXAS (ALCOHOL ONLY)

There was an increase in demand for services due to a growth in the State's population which was caused by an in-migration of people from other States. However, sufficient resources to meet the increased demand have not been realized.

No programs closed as a result of reduced funds; however, one chose not to continue services for other reasons. Former NIAAA grantees were awarded 25% less funds due to the cut in federal funds. In some cases the grantee reduced the size of the catchment area it served; in other cases the services were modified, and in other cases the agencies replaced the lost funds through active fund raising efforts at the local level.

WEST VIRGINIA

Service demand had increased due to an public awareness; a court mandated increase in services to the public inebriate; compulsory treatment provisions for DUI offenders.

Although there have been an increase in state allocations, it has not been sufficient to meet the demand. No one is turned away, but the level of services available is insufficent. Our particular needs are: increased prevention programming; residential treatment programs for adolescents a long-term residential treatment program for the chronic alcoholic; and, expanded residential treatment capacity.

The reduction in federal funds has not been met by an equivalent increase in state funds. The most dramatic area of service reduction has been in prevention, with a reduction in services of at least 50 percent. A statewide reduction in outpatient treatment staff of at least 20 is compounded by the fact that remaining staff are frequently not designated solely as substance abuse staff. Caseloads have increased. Services are offered on a less frequent basis, and there is less variety in the services offered. There is no training money. State level administrative staff have been reduced by 3 professional and 2 clerical positions, including the prevention coordinator and the training coordinator.

WISCONSIN

Demand for alcohol treatment and prevention services in Wisconsin has increased dramatically as a direct result of the emphasis on intoxicated drinking enforcement. Unfortunately, at the same time that the demand for treatment and prevention services has increased there has been a decrease in available resources at local level both in relation to the number of clients which can be served and the number of program staff which are supported by the public dollars. Also, monies in recent years to allow the programs to keep up with inflation. Expansion of services is at a standstill.

The 56 alcohol and drug services county board across the States received 4 percent decrease in Federal dollars in FY 84-85. Milwaukee County is scheduled to lose appoximately $80,000 in block grant dollars in the coming year and amount which is equal to their treatment programs.

WYOMING

Demand for services has remained stable. The state of Wyoming has used general funds to augment the declining federal funds. We have continued support to all previous categorical recipients but have reduced the level of two NIAAA projects by 15 percent per year. FY 85 will be the last year that the two NIAAA projects will receive funds. One, a small poverty program, will probably close after FY 85.

ATTACHMENT B

*Question.* If Congress increased the ADMS Block Grant award by 10 percent how would you utilize the additional monies?

Answers.

*Arizona (drug only).*—Arizona would set $9,794,400 instead of $8,904,000 or an increase of $890,400. The drug abuse share of the higher award would be approximately $2,867,487 ($260,681 more than the FY 84 portion). This limited increase would be used simply to attempt not to lose as much in service capacity as would disappear without the $260,681. All scenarios played out within the Department show a loss in funds even with a 10 percent increase in block funds. A related effect will likely to be the loss of some locally derived funds that contractors provide to match state funds.

*Arkansas.*—Priority areas for the State of Arkansas are listed as follows and are not in rank order necessarily:

(1) Overutilization of existing treatment programs.

(2) Efforts directed toward youth.

(3) Efforts directed toward women.

*California.*—The State would use any increase for additional consideration of special population groups, prevention efforts, and Employee Assistance Programs. Also, pending the outcome of the Sundance case the public inebriate problem would be given more consideration.

*Connection.*—Connecticut will experience in FY 1985 a shortfall in federal funds nearly equal to 10 percent of its ADM Block Grant. The additional 10 percent, therefore, would be used to maintain the existing needed system of services including a very modest inflationary increase. It would not be possible either to expand the present system or develop new programs.

*Delaware.*—Any additional funds, if in sufficient amounts, would likely be used to assist us in providing services not currently existing in our overall system (residential drug abuse rehabilitation; partial care/day care; long term alcohol rehabilitation; etc.) some of which would effectively target special groups. Existing programming, especially our outpatient services, needs to be enhanced to provide increased accessibility in all geographic areas. Special groups would benefit from this as well. We would greatly prefer, however, that any additional funding not be specifically earmarked for special populations.

*Florida (drug).*—The State would utilize additional monies to emphasize the importance of good residential care; to evaluate the effectiveness of our outpatient drug treatment services and maybe add to existing services; and to target special population groups (especially to coincide with ADAMHA and OJJDP's juvenile justice initiative) and minority youth (blacks and hispanics).

*Florida (alcohol).*—There are several proposals now pending in the State legislature. If an additional 10 percent was awarded through the Block Grant the State would use it to try to realize those proposals. They include: An increase in domiciliary services; bring all community programs up to equity; increase residential outpatient services for alcohol abusing youth; provide alcohol court/law enforcement liaison services; provide specialized alcohol abuse prevention and treatment services to the elderly (approximately one-third of the Florida population is over the age of 55); provide specialized treatment, prevention/intervention services to children of alcoholics; increase DWI services; and provide specialized prevention and treatment services for women.

*Georgia.*—DUI offender evaluation and intervention efforts. Increase in prevention and training programs.

*Illinois (drug only).*—If the ADMS Block Grant award level was increased by 10 percent the State's number one priority would be to try to eliminate the client waiting lists and treatment overcrowding. Other efforts would include: the development of better and more specialized services for women; expansion of prevention services Statewide (especially to minority youth and rural communities); and development of more specialized services to youth.

*Iowa.*—A 10 percent increase would be used to help expand publicly-funded programs, increase residential services, and as much as possible would be targetted to prevention efforts.

*Kentucky.*—If the Congress increased the level of the ADMS Block Grant award by 10 percent consideration would be given to programs with waiting lists for program expansion. Some of these include transitional care for women, transitional care for men in urban areas, new detoxification facilities in Northern Kentucky and South Western Kentucky.

School-based prevention programs (peer counseling, early intervention, teacher curriculum training) and special services for women would also receive priority consideration. In addition, detox and residential services for youth are a priority for new funds.

*Louisiana.*—Would provide for special programs to address:

(*a*) The physical abuse in families, i.e., child abuse (also see item "c") spouse abuse, geriatric abuse, which has a high correlation with the use of abuse of alcohol and drugs.

(*b*) Women and their dependent children in treatment and halfway house settings.

(*c*) The high incidence of child abuse by teenage single mothers (85 percent) who are alcohol or drug abusers (70 percent).

(*d*) The high incidence of suicide in the chronic recidivist alcoholic.

(*e*)The critical need for expanded efforts in the areas of prevention and education. Suggest beginning before kindergarten.

*Maryland.*—The primary use of any new monies would be to relieve the strain on our opiate addiction treatment network. The second priority would be to impact upon youth between the ages of 14 and 18, and the third priority would be to use 20 percent of any increase in our ongoing prevention efforts.

*Massachusetts.*—They would be targetted for special populations:

(1) Youth residential treatment programs, and

(2) Two hispanic half-way houses.

*Michigan.*—Any additional funding through the federal block grant would be generally evenly applied to prevention efforts and treatment services (particularly for services to indigents and unemployment persons).

*Minnesota.*—Additional monies would be targeted to providing treatment services to public assistance clients and others with no sources of funds.

*Missouri.*—Additional revenue for the Alcohol and Drug Abuse Program services would be utilized to provide a minimum core of detox, residential and non-residential services in those service areas where currently no services exist.

*Montana:*

Assist to maintain current services for publicly funded treatment programs.

Provide additional inpatient care for indigent population for areas of the state not close to the State Inpatient Treatment Center.

Provide treatment services to youth.

Develop transitional living facilities in needed locations.

*Nevada.*—If a 10 percent increase were given we would use it to ease the strain on over utilized programs, e.g. increase wages, fringe benefits, improve clients' meals, improve facilities, etc.

*New Jersey:*

Increase funding for over-utilized treatment.

Increase federal and state share for treatment costs. For example, a residential bed receives only $4,500 per year.

Provide more services for youth. At the present time only 5 percent of treatment services are for youth.

Provide services for cocaine abusers and prescriptons drug abusers (especially women).

Expand community/school intervention services.

*North Carolina.*—If additional state funds are not appropriated for FY 1984-85 a 10 percent increase in the alcohol/drug block grant would be used to maintain existing services levels. If additional state funds are appropriated a 10 percent increase would be used for the following purposes: to facilitate the deinstitutionalization process by the development of community services needed to replace those services previously provided by three of our state mental institutions; to provide training necessary to increase quality of services delivered; to provide for case management services, which in addition to increasing quality of services, would also promote a more effective use of existing community resources; to increase program utilization through the development of more extensive outreach services; and to increase prevention programming.

*North Dakota.*—Any increase would be used only to partially close the quality gap. A 30-50 percent increase is necessary to close the gap completely. No new programs could be launched unless the increase is substantial.

*Ohio (drug only).*—If only a 10 percent increase would be given, services providers would be able to:

(a) Fill many vacancies among treatment and prevention staff.

(b) Give staff salary increase (in some cases, there have not been any increases given in over two years).

(c) Serve some of the clients on waiting lists.

(d) Increase the services provided to adolescents.

Grant reauthorization the funding level be returned to the FY '80 level. This would provide necessary funding for:

(a) Additional outpatient and residential treatment services for women, adolescents (especially those identified through prevention programs), mentally impaired (especially those who are chronically mentally ill), those without sufficient resources to cover treatment costs, those with sensory and motor impairmants, and employee assistance programs.

(b) School and community based prevention programs especially for: minority populations, employees, prescription drug abuse, professionals, and those with sensory and motor impairments.

(c) Increase substance abuse services in rural areas.

(c) Community-based services for those leaving the correctional system where treatment services were initiated.

*Oregon.*—With additional funds we would bolster our outpatient service capacity in general, and in particular, we would increase service to youth and the elderly.

*Pennsylvania.*—Pennsylvania would prefer to see any increased federal support expand the existing block, instead of reverting to former categorical approaches, with special target population set-asides or state demonstrations. Most states can easily determine their own state and local priorities. In the case of Pennsylvania, our decentralized State-County partnership will continue to give counties flexibility in matching resources to needs.

Therefore, we will not superimpose more target populations; but will continue to rely on our statewide planning process to determine local priorities. The funds would go for treatment except for the 20 percent share of the increase for Prevention/Intervention. Populations needing treatment are so numerous in our communities that a reasonable mix of women, minority groups, youth, elderly, unemployed, homeless, etc. will be better served with increased funds. Target groups will vary from county to county.

Pennsylvania perceives that our current level of federal prevention/intervention support is adequate. Hence any increased federal funds above the 20 percent prevention/intervention minimum will go to treatment unless a county can document that its treatment needs are met and its prevention/intervention efforts need further development.

*Puerto Rico.*—If there were to be a funding increase, some satellite centers could be reopened, the prevention centers reopened, and some funds dedicated to laying the needed groundwork for eventual third-party reimbursement and increased private sector participation.

Development of programs which provide residential and thereapeutic care for women alcoholics and drug addicts; programs which address the subpopulation of women alcoholics and drug addicts such as, elderly citizens youth, incarcerated women, and others. Development of an orientation telephone line program for the community.

*South Carolina.*—This depends upon our success in obtaining additional state funds for FY 85. Presently, our chief funding need is to provide additional support to the outpatient treatment program. Following that we need to bolster our school prevention and intervention programs. This is how we would use it if no state funds are obtained. If we are successful, any additional funds would be used to look at special populations and programs in the schools.

*Texas (alcohol only).*—In the area of treatment, the Commission would increase the amount of services purchased. The costs for services range from $40–$60 per client for non-hospital based detoxification, $25–$35 per day per client for halfway house services; $25–$55 per hour for outpatient counseling services. We would also increase funds for case-finding and early intervention services as well as primary prevention (services for children of alcoholics, school curriculum).

*West Virginia.*—A 10 percent increase in the ADMS Block Grant would give the West Virgina substance abuse program an increase of only $120,000. Our first priority for the use of this money would be to increase prevention programming. We would hire a full-time prevention coordinator, and use the remainder for special prevention projects, similar to "Channel One", aimed at regionally identified at-risk populations.

*Wisconsin.*—Any increase in Federal ADMS Block Grant dollars would be used to offset recent reductions in support to the 56 county boards. As the ADMS Block Grant priorities set by the State include a special emphasis on minority target populations the increase would result in a direct improvement in services for these special populations. Two programs which address the prevention needs of Indians and women currently receive the highest priority under the ADMS Block Grant.

*Wyoming.*—The additional funds would be used to maintain the categorical programs and could offset the 15 percent planned reduction.

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TESTIMONY ON BEHALF OF RICHARD J. RUSSO, M.S.P.H., ASSISTANT COMMISSIONER, ALCOHOL, NARCOTIC AND DRUG ABUSE, NEW JERSEY STATE DEPARTMENT OF HEALTH, TRENTON, NJ

I. THE OFFICE OF PREVENTION

Operation since November of 1979, the Office of Prevention is a Unit within the State Department of Health, Division of Narcotic and Drug Abuse Control.

The goal of this Office is to coordinate, indentify and deliver meaningful services to the communities within the State: rural, suburban and urban.

New Jersey's primary prevention initiative continues to be replication of the Statewide Community Organization Program (SCOP). The SCOP Program was begun in response to a Federal requirement to demonstrate the State's ability to coordinate systems and local prevention efforts.

The intent of SCOP is to train and assist teams of New Jersey School and community leaders in developing and implementing programs for the promotion of positive adjustment among youth and the entire community.

Numerous approaches have been attempted by state local communities to prevent unacceptable activities from occurring among youth. However, the majority of these approaches were directed toward specific activities ranging from poster campaigns, pamphlet or literature distribution, to the development of school curriculum. Over the years the various disciplines have tended to take an insular approach—believing their specific activity alone would significantly address the problems they faced. Frequently lost in this maze was the realization that the problems of youth crime, delinquency, drug abuse, truancy, runaways and so on, are multifaceted in cause and, as such, the solution must be multi-disciplinary in approach.

We believe that most problems facing our youth today can be resolved on the Community/neighborhood action level and not by advisory councils and planning commissions. We embrace a behavioral health approach to problems with youth. This takes into account not only the physical and psychological factors but also the social and economic well being of individuals. It takes into account the belief that a variety of youthful "misconducts" including drug abuse are all symptoms. It is further noted that only by focusing on root causes rather than symptomatic ills can fundamental change occur.

In summary, the Office of Prevention provides this behavioral health philosophy from which all programming emanates. We have taken the firm position that community organizing is the most effective and feasible way to address cause and effect real change. It gives communities and, in turn, the entire State a collective sense of identity, purpose and direction as it relates to behavioral health problems.

In the past five years numerous SCOP teams have been trained and have joined together to form a network of prevention programs. There are currently over 100 trained New Jersey communities in this network.

II. SEEDS OF THE SCOP MODEL: HISTORY OF A LOCAL EFFORT

The Model used by SCOP is based upon the local efforts of a New Jersey community whose primary focus is interagency coordination and early intervention and prevention of youth school/criminal justice/and community problems inclusive of drugs and alcohol.

In an effort to improve health rather than to treat illness, one particular New Jersey community, for the past eight years has worked on developing, implementing and evaluating a multi-faceted approach to prevention with measureable outcomes. Recognizing in 1972, that there was as increasing problem of drug abuse, vandalism, etc., by juveniles in their community, the Superintendent of Schools and Chief of Police sent community representatives for an intensive two-week training at the Adelphi University National Training Institute. The focus of this training was to "help communities to help themselves." This was accomplished by attending workshops on Human Relations, Team Building, and Program Planning. The teams were introduced to concepts of prevention programming and systems theory, but the most important byproduct, intentionally or not, was a trusting relationship developed among the seemingly divergent team members.

In 1977, at the invitation of a former United States Senator, a noted New Jersey community testified before the United States Senate Subcommittee on Alcoholism

and Drug Abuse Education. The Senator assessed the local program efforts as "a model for other communities to follow." It was stated that:

". . . a community team involving the police and school based team, have worked in a most innovative and productive way in the community and school."

". . . (In this community) children consider policemen friends to whom they can turn for help. Senior citizens work within the school system helping to bridge the generation gap and helping children overcome problems of low self-esteem and poor performance. In this community, children have challenging outdoor activities, involving the school and the police. Youngsters act as park leaders, running the parks at night for themselves. No arrests for loitering have occurred during the past three years, because such arrests were no longer necessary. Vandalism remains consistently at a low level, while the rate of other towns steadily increase. Young people have healthy and happy places to congregate with their friends. In this city young people know what help is available to them in the community, whatever the problems."

(Statement of the Senate Committee on Human Resources Hearings of the Subcommittee on Alcoholism and Drug Abuse. 9:00 a.m., March 24, 1977).

Clearly, while programs that have been designed are based upon the need of one community, the process of community organizing is replicable to others (urban, suburban and rural). From the Bergenfield experience, we have drawn a Model Program, or more accurately, a community-based process for change. The Office of Prevention contracted with the Bergenfield team as trainers and consultants to SCOP teams. The use of working policemen, principles and other community leaders to share their successes and failures was found to have high credibility and impact on other communities looking for direction and struggling to address their own problems.

### III. WHO PARTICIPATES

Within New Jersey, as all States, communities are widely diverse on their economic, social and demographic make-up. Irregardless, it is our experience that the SCOP process is indeed replicable in any community with some modifications. For example, in urban areas our focus is on building teams that represent neighborhoods rather than one team to represent the entire city. In rural and regional areas we may build a school/community team to focus on one school.

So taking into account demographics, the target population and type and extent of the problems the SCOP process begins with each community forming a team. This team consists of 6–7 school/criminal justice/community based professionals and volunteers inclusive of elected officials when possible. Recognizing the difficulty in formulating a team which is somewhat reflective of the community, we intentionally require, minimally, one person from the following community institutions and groups:

School: Superintendent, Assistant Superintendent, Principal and/or Director of Guidance, Child Study Team

Policy: Police Chief, Juvenile Officer

Community: PTA, Parent, Board of Education Representative, Town Council, Minister/Priest, or Civic Organization, Elected Municipal Person

These three participating groups are essential for optimal efficiency.

*Why are the school, police and community identified as important for goal accomplishment?*

Because it is the intent of the Office of Prevention to have impact on the social ills of today by utilizing the social networks, institutions and settings that significantly influence the development of the youth to be serviced. Within this framework is recognition of the importance of institutions for providing structure in our communities and the potential for using care givers within these institutions to act as change agents. The school, police and local government (elected officials), are identified because they are permanent institutions found in every community across the nation—urban, suburban and rural. Although these institutions are not the only permanent institutions in the community, they are utilized because of their potential influence on youth, either in a positive or negative way.

The schools are high impact institutions which have the responsibility of preparing youth for full adult responsibility through education and demonstration of model deportment.

The police are identified because of any aberration of behavior deportment eventually involves the police, especially if the activities involved are illegal consumption of alcohol or illicit use of drugs.

The local government (elected officials) is utilized because they serve as the representative voice of the community, the nucleus of which is the family.

### IV. SCOP TRAINING: PURPOSE AND RESULTS

Communities who have applied for and been selected to take part in the SCOP process initially receive an orientation visit from a Prevention office staff member. Following is a specifically designed three day workshop. The goals of this training are as follows:

To build a multi-disciplinary school-police-community problem solving team as a result of participation in the program.

For the team to acquire skills in group dynamics which will help them survive as a group after the training.

For the team to acquire skills for clarifying a social problem which is of relevance to their community and/or schools.

For the team to acquire skills for developing a solution to the problem in the form of a written program design.

For the team to implement the proposed program and begin to evaluate the outcome.

As was stated earlier the approaches communities come up with are diverse and reflect their unique needs and problems. In Evesham the SCOP team sponsored an "Adopt-a-Cop" program, which seeks to improve the relationship between police and youth. They also were instrumental in creating a RAP Room where adolescents can drop in to discuss problems at home or school. A Primary Prevention Program by which classroom teachers seek to identify adjustment problems in youngsters as young as six or seven, has been implemental in Gloucester Township. The goal here is to build a youngster's trust in adults and change the negative way in which he views himself/herself. In Paterson the SCOP team was interested in providing the inner city youth with positive role models. They invite adults with different professionals to come and share their experiences with the children. At Hawkins Street School in Newark, sixth graders come early to school and stay late to tutor second and third graders with learning problems.

In Hanover Park, the "jocks", scholars, withdrawn, average and "high risk" students, boys and girls alike are joined together in a leadership program. The youngsters take part in a wilderness "outward bound" type experience and then each volunteers service hours back to the community. In Marlboro Middle School, students "Adopt-a-GrandParent" Program teams youth with the elderly in a local nursing home. Bloomfield has established a program for teens that drop-out of school which focuses on attaining their certificate, employment training and counseling. In Livingston, a Single Parent Program has been designed to help reduce the negative, emotional and social factors associated with divorce and separation which can lead to poor school grades, substance abuse and juvenile delinquency. The Secaucus SCOP team has sponsored workshops for the local school coaches addressing the issue of substance abuse in sports and the stress that youngsters are put under to perform and win. In Roselle Park, programs such as the Halloween Mischief Night Concert, Pride-in-Self-Pride-in-Community two and five mile runs, leadership development classes and a Big Brother-Big Sister Programs are all examples of the SCOP process.

What has been mentioned here is a random sample of a variety of programs. What they have in common is that the cost of low and in terms of early interventions and prevention the benefits are high. It was interest in this connection between cost-benefits and prevention programs that led to a preliminary study.

An addendum is provided of the cost-effective study conducted by outside researchers in 1982-83 in four diverse communities: Bergenfield, Newark's Franklin School, Scotch Plains and Gloucester Township.

### V. SUMMARY

It is a basic belief of SCOP that no one knows the problems and resources of a community better than the people living in that community. Given meaningful training and assistance, there is no one better equipped to formulate possible solutions to identify problems that those very same community members.

Abuse of drugs is assumed to be one of a number of self-defeating, negative responses to emotional pain. SCOP contends that by presenting youngsters with accurate information in a supportive environment and by fostering, positive attitudes towards herself/himself and others, the individual is less likely to turn to drugs as a solution to distress. An individual would more likely apply his or her knowledge and make an intelligent decision to manage life stress without resorting to chemical sub-



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stances. Further, if there is a supportive rather than punitive climate in a community, youngsters under tremendous stress or in difficulty will know where to turn for help.

The funding and manpower needed to plan and operate programming is a major concern. SCOP programs need not cost tax payers large amounts of money. When funds and resource for programming operations are needed, SCOP teams have come up with creative solutions to raise funds and mobilize under-utilized resources. Such an attitude maximizes the creativity and energy of both adults and students.

The Statewide Community Organization Program taps into the old idea of "self-help", an ethos at the core of our culture. With pessimism setting the tone in social service arenas and individuals feeling low on options and morale, SCOP has been a process to give people back some control over their lives and that of their children. It has been a process to address the concerns people have for their youth and make them actively involved in solving those concerns. It has been a proactive process to coalese a variety of groups, fragmented in terms of vested interests, rhetorical and ideological concepts and differentiated expertise. This is not a panacea nor a miracle formula. It is difficult work for which we need patience, the ability to risk and a long view. It is an effort to build strengths rather than continually counter-attacking deficits. It is only one approach. For the field of prevention Willian Shakespeare may have said it best when he wrote: "A little fire is quickly trodden out, whilst being left to suffer even rivers cannot quench". We can no longer afford the cures.

The New York Times
Section 12
April 15, 1984

# EDUCATION

SPRING SURVEY

**SCHOOLS THAT WORK:** 10 PROFILES

## Parents' Mops and Paint Save Newark School

By ALFONSO A. NARVAEZ

NEWARK

FRANKLIN SCHOOL literally rose out of the ashes. Ideal Charles P. Mitchell, who took over as principal of the elementary school here in 1976 after a fire set by neighborhood youths caused $200,000 in damage. "After the fire," he said, "the building was in shambles and the outside had so much graffiti it looked like a New York City subway train. There was low teacher and student morale, a lot of discipline problems, and lots of parent apathy and recent outrage. But with strong community support that he was able to mobilize, the school now thrives amid its grim surroundings.

In Franklin's neighborhood, a run-down section of central Newark, the use of drugs is rampant and blocks of burned-out buildings abound. The school's turbulent 19th-century architecture reflects a bygone era: nearby streets and vacant lots are strewn with trash. But as a visitor approaches the school, at 42 Park Avenue, he sees a structure painted a bright brick color, with graffiti at a minimum. The front door is emblazoned with the motto "We're So Proud," and at a touch a buzzing security guard prompts it open.

Inside there is an air of near-serenity, even though the school is overcrowded, with 1,314 students in a building designed for 630 and as many as 32 students in some classrooms. In one class the children, mostly Hispanic, are busy at their desks while the teacher gives close attention to a small group working on phonics.

After the fire in 1976 the previous principal left in disadvantageous and Mr. Mitchell, who had been assistant principal, took over. The school's turnaround began, he said when he called a community-wide meeting of parents, teachers, students, local businessmen and community leaders. "After they had analyzed all the problems of the school their number one priority was not the reading scores or the curriculum," Mr. Mitchell said. "Their number one priority was to get the building physically looking attractive. They said the building did not represent a school that was taking itself seriously."

He said that the Board of Education had not scheduled the school for repainting until six years hence, in 1982. But parents and community leaders decided to solicit contributions from local businessmen and paint the building themselves after the damage had been repaired. "We all worked together on that," said Josephine Zambrana, who said that her two elementary-school-age children and her husband had assisted paintbrushes and mops to clean up the school. "The parents were very cooperative. Now we have a fantastic school and a fine teaching staff."

Another parent, Ida Reyes, whose daughter Alma has gone to the school for the last six years, said that as one result of the community's mobilization parents went around the neighborhood handing out stickers asking people to call a special Vandalism Hotline that they had set up if they saw anyone spraying graffiti or trying to break into the school. "We asked them to keep an eye on it for us and they did," Mrs. Reyes said. "We haven't had any problem with the school being vandalized."

Despite the environment outside the building and that fact that more than 80 percent of the children are from low-income families, mathematics and reading scores have improved dramatically as recent years, and chronic absenteeism has been virtually eliminated. Compared with

The New York Times / Jim Cummins

Newark schools in the city with similar enrollments, Franklin now ranks fifth in mathematics, up from 26th in 1978-79, while in reading it ranks 16th, up from last place during the same testing period. As for attendance, one of the most telling barometers of a school's effectiveness, Franklin boasts a 93 percent attendance record for 1983, up from 81.2 percent in the 1976-77 school year, placing it third among all 68 elementary schools in the city.

Mr. Mitchell said that for the first three years of his tenure at Franklin "we did everything we could to create an environment that maximized the negative elements of the school's blighted environment and maximized learning and teacher teaching. One of the key elements was parent involvement."

To develop this, he said, teachers and administrators first visited homes to talk about the school and interest them in their children's education. Then, to maintain that involvement, he decided not to send report cards home but to ask parents to pick them up at the school. "At our first open house," he said, "we had 1,200 parents come in and ago for report cards." As a result of this effort to enlist parents' aid has been that volunteers now regularly work in classrooms assisting teachers.

The positive atmosphere at the school had attracted innovative programs. Teachers College at Columbia University selected the school as a site for a project that seeks to use the cultural experiences that teachers and children bring to the school to improve curriculum. "When we came here," said Yvonne DeGennaro, director of the project for Teachers College, "we found an atmosphere of respect for kids, of teachers who were not angry and a principal who was talking to parents like they were human beings and not enemies. We felt like we had an atmosphere where learning can happen."

## A Blend of Parents and Teachers

By FRANCES FRANK MARCUS

NEW ORLEANS

AT Joan Gordon Elementary School in New Orleans, one of the three top-performing schools of the city's 78 public elementary schools, the key to success is the "mix" of both parents, as well as highly competent teachers. "Without a strong parent group," said the principal, 36-year-old Brian Riedlinger, "you can have a good school but you can't have a great school, no matter how hard the teachers work."

"The bottom line is the teacher," he added. "If you have a good teacher, the kids do well. If you have a poor teacher, the kids don't do well."

Mr. Riedlinger, who came to Gordon in 1978, commented on parent-teacher interaction. "The biggest problem in American education is that we have allowed kids to drive a wedge between parents and teachers. Kids are masters at that. What we're trying to do is let parents know that if you have a problem with the school, be sure to let us know but don't let the kids know. We emphasize to parents that we're on this together."

To emphasize the point, he spun around in his office desk chair to show how he arranges the seating at conferences with parents and students: "We could sit behind along one wall of his office, facing another wall. As the conferences proceed, th

> 'We have allowed kids to drive wedge between parents and teachers'

the principal moves his chair so that he and the parents are together on one side of the room facing the child.

The support provided by parents of the 640 children at the school includes help with homework; attending twice-a-year report-card conferences, painting the interior concrete-block walls of the 35-year-old, sun-air-conditioned school building, selling candy (nearly $20,000 worth this year), running an school fast races and conducting the music at the school's jazz and heritage festival.

Last year parents contributed $18,000 in revenue from various sales, dues and other fund-raising activities to school cultural programs, equipment and classroom supplies. Because New Orleans has unusually low property taxes, the public school budget can cover few frills.

A parent study group helped choose the school's phonetic system of reading instruction, the Addison-Wesley Reading Program, which parents and teachers like for its brightly designed workbooks and catchy phrases. Gordon is the city's only public elementary school to use a phonics

*Frances Frank Marcus contributes to The Times from New Orleans.*

# Township of Evesham

RESOLUTION NO. 69-84

RECOGNITION OF SCOP

WHEREAS, the Marlton State Community Organization, SCOP, is a team of professionals who endeavor to improve relations among school, students, police and residents; and

WHEREAS, SCOP, who for the past five years, has worked with the youth of our community in the areas of drug and alcohol abuse; and

WHEREAS, some of the programs implemented by this team are:

RAP ROOM - A Township sponsored center which is geared to help adolescents and teenagers to overcome problems through various workshops;

ADOPT-A-COP - A program whereby police officers visit classrooms and participate in various outings throughout the year so that students can see and get to know these officers in their work environment as well as a non-working atmosphere;

PROJECT USE PROGRAM (Urban and Suburban Experience) - A program whereby high school students spend three days in the wilderness with a team of trained guides and learn about nature and working together for survival; and

WHEREAS, this team has been selected from more than 100 trained prevention teams as one of the three best State Community Organization Programs in New Jersey; and

WHEREAS, the Township wishes to recognize the outstanding work which SCOP has accomplished in helping the teenagers of our community.

NOW, THEREFORE, BE IT RESOLVED by the Township Council of the Township of Evesham, County of Burlington, State of New Jersey that we hereby congratulate and commend the following members of the SCOP Team and recognize your outstanding efforts

# *Early start advised to halt juvenile crime*

By SHERRY FIGDORE

FREEHOLD TOWNSHIP — Traditional methods of dealing with juvenile drug addiction and vandalism have often involved bringing in drug addicts to scare the kids and police to threaten them.

But with fast-changing social mores and family structure, the traditional methods have largely failed.

"By the time I get a case to prosecute in juvenile court," Monmouth County Prosecutor Alexander D. Lehrer said yesterday, "it's already too late."

"Those kids," he said, "are already on a course leading to adult criminal behavior."

Early intervention, taking programs to children as young as kindergarten age and cooperative community programs appear to many experts to be the only solution.

One such cooperative program being advocated by the state Department of Health stresses a positive, community-wide approach, bringing community leaders, students, school administrators and police together in a joint effort to build school and community spirit.

During a workshop on the State Community Organization Program held here yesterday for about 80 persons, Bergenfield Police Sgt. Donald Stumpf said police and school officials must work together more closely.

The most important step, Stumpf said, is to identify the particular needs of the kids in each community.

In Bergenfield, which began the first SCOP program in the state six years ago, Stumpf said half of the students in two schools come from single-parent families.

Youngsters with one parent, or two working parents, will have five or more hours a day to fill, the sergeant said. School and community programs must be developed to fill that time constructively.

"I have yet to see a window broken from inside a school when kids were playing in it," Stumpf said. "Windows get broken in closed schools, with chains across the doors."

Bergenfield has developed what he calls "catch basins," bringing in senior citizens to supervise classrooms open for play periods until 5:30.

Stumpf said police have to change their image with kids. And they need to begin preventive programs much earlier.

"We're wasting our efforts with the junior and senior high years. We belong in prevention programs in elementary school."

Gale Kavanagh, training coordinator in the state Health Department's Division of Narcotics and Drug Abuse, said the "only thing consistent about prevention programs in communities is the rhetoric."

"Many communities think they have prevention programs," she said, but there is little community support and less money.

Kavanagh lauded the Bergenfield program, which includes a police-sponsored "Outward Bound"-type of program for youngsters heading for trouble, and has used its SCOP team to train teams in 80 other communities around the state.

The six-member Scotch Plains/Fanwood SCOP team described its experiences for the workshop in building such a program over the last two years.

Team building and raising school spirit is central in an approach that Dr. Terry Riegel, principal of the 1,700-student Scotch Plains/Fanwood High School, said is based on the idea that "if kids are happier, there is less vandalism."

The SCOP team began planning two years ago for a tightly structured weekend conference last fall for 48 students and six teachers. Financing came largely from local businesses and civic groups contacted for donations by the students.

While it is too early to detail positive results of the program, officials said there is a new and real commitment on the part of students. The school and police are now working on developing contracts with miscreant adolescents, to allow them to work off minor offenses.

Milton G. Hughes, Monmouth County superintendent of schools, whose office co-sponsored the workshop with the Monmouth County Violence and Vandalism Task Force, emphasized the importance of the SCOP approach in stemming the increasing amount of juvenile vandalism.

Hughes was also concerned that as the population grows older, "child advocacy is rapidly disappearing."

"Today, 73 percent of the adult population have no school-age children," Hughes said.

"The question I have, is who is speaking for youth today?"

Register 3-31-82

129

Wayne Pfleg gets a helping hand over the twelve foot wall.

Dr. Terry Segal signs a lighter moment.

## Leadership Conf. provides motivation for students

The success of planning this year's Student Leadership Conference culminated in a very successful weekend for 32 high school students and teachers on the weekend of November 10, 11 and 12.

The weekend workshop in leadership was planned and led by the Student Planning Council Delphi Team who had been trained by an outside consultant team. Seven months had been devoted to planning a series of workshops and school activities and programs with the focus on motivation.

The Delphi Team consisted of Dr. Robert J. Hansen, superintendent of schools, Dr. Terry E. Segal, principal of the high school, Mrs. Mary Ann Pugh, vice principal of the PTA Council, and public officers Captain James Lunt and Sheriff's Corporal Bill Shanks. The consultant team are the services of Leadership Dynamics, Inc. of Rochester, New York, and with their professional expertise in leadership conferences helped the Delphi Team in developing a program of activities and workshops which would motivate, stimulate confidence in self and others, and develop a sense of responsibility and an awareness of what the young people can do when properly motivated.

During the activities of the weekend, which was held at the national camp of the Genesee YMCA Camp near Port Jervis, New York, the students were divided into groups with a leader or team leaders for facilitation. The groups, representing all grades in the area 9th or the high school, were challenged throughout the weekend to develop their leadership skills, and by the end of the weekend each group identified a problem in school and developed a plan of action to be presented to the school body.

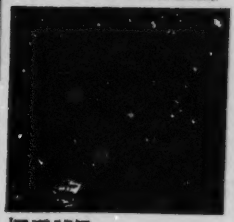
The Delphi Team consisted originally of Wayne Pfleg and Wendy Thurber. Thurber is the Camp Greenhill to act. Portland the efforts of all to school. Mayor Thurber was unable to attend and was replaced by Wayne Pfleg. Mayor Thurber made the invitation at the early and joined them in a number of activities, including a movie that night. The movie introduced one to use group interaction and was very interesting.

Many first problems were then identified by the students at last year's Conference, among them a homecoming parade of the band, float of the school and the [illegible] of a [illegible] dance. Many ideas of a permanent community action were set in motion at the conference with the support of the Valentine Day and the planning of the [illegible] with the Delphi Team.

Included in the projects planned by the year's conference are an [illegible] and hallways [illegible] program run by the community, a Valentine Day and Mother's Day and school activities, an assembly [illegible] Leadership Foundation program and an improvement in the [illegible] appearance of the high school.

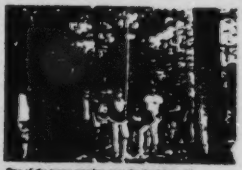
Local organizations have been most generous and the success of the conference is in large measure due to the support given from private sectors as the Fairwood-Seacliff Pirates Booster, the Service Club, UNICO, Seneca Pines Lions Club, Sheldrake Community Association of Terrill and Port Middle Service, the Masonic Temple, Club, the High School PTA, Terrill Lions Club, the Seneca Pines PBA, the Senior Class of 1980 and Mr. Thurber's team of the 1981 Student Leadership Conference. The students participated in a car wash, car washes and other student fund raisers.

All involved in the planning and implementation of this weekend have expressed a sense of professional satisfaction in working toward a common goal and look forward to a reunion conference. The students attending the conference, Carol Oakes, Karen Schramm, David Gowdy, James Meeks and Jeffrey Bell, were quite pleased and excited and are anxious to see the students, with encouragement for the year ahead. All involved hope to see a continued growth of interest, enthusiasm and involvement in the future for the benefit of students and community.



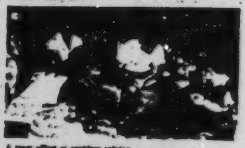
Team work at its best.

Chris Evans explains his team's project at the end of the weekend.



One of the teams working over the "walk wall".

It only looks easy!



A team effort at problem solving.

Brainstorming new different questions.

Leadership begins to emerge.



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NA Friday, November 27, 1981 [illegible] BD

# Communities tailor aid programs to fit need of juveniles

## Towns go their own way in preventing juvenile crime

By FREDDA SACHAROW
Of The Bulletin Staff

Communities are taking a smorgasbord approach to solving their problems with youth, picking and choosing among a varied menu of programs and projects supported by the state.

Cherry Hill is compiling a directory of resources and services available to its residents. Evesham is sponsoring "Adopt-A-Cop," a program under which police officers make regular visits to the township's fifth grades to establish rapport with the youngsters. Gloucester Township is emphasizing a "Primary Prevention Program," which seeks to identify children with potential problems as early as first grade.

Linking together these efforts — and those of 70 other municipalities up and down the state — is the State Community Organization Project, a three-year-old, Trenton-based program with one underlying aim: Prevent juvenile crime and drug and alcohol use.

"We believe each community should decide for itself what its own problems are, and decide on its own solutions," said Barbara Wright Bell of the Division of Narcotics and Drug Control Abuse of the New Jersey Department of Health.

"Our ultimate goal is to get communities involved. The more involvement, the greater the chances of dealing with all kinds of behavior."

Begun three years ago, SCOP (pronounced "scope") trains teams of representatives from interested townships, including police, school board members, clergy and educators. Participants learn how to join forces to deal with such specific problems as vandalism, drug abuse and truancy.

"The training gave us a sense of the importance of having a community working together, so that if something does crop up, you already have the mechanism to deal with it," said Eleanor Stofman of Cherry Hill, who last year spent three days in Bergenfield in Bergen County observing successful programs that township has developed.

Armed with these models, Mrs. Stofman and the six other members of what ultimately became the Youth Coordinating Council of Cherry Hill decided that one of their first projects in the sprawling Camden County township would be a directory which lists all of the local health, social service, educational and recreational resources.

The directory will be distributed to all township residents early next year.

"We felt such a directory was necessary when we came back from Bergenfield and realized that we already had many of the programs they were teaching us about," said Mrs. Stofman. "But members of our team didn't always know what other resources were available. And if we didn't know, how could the rest of the community?"

A future project of the Cherry Hill group — whose members include a junior high school principal, the director of the township's social service program and a representative of the police department's juvenile division — is a series of family workshops.

The free group sessions will be open to parents and adolescent children and are designed to open communications between the generations, Mrs. Stofman said.

According to Ms. Bell of the Division of Narcotics and Drug Abuse Control, each township is free to select its own avenues of self help. Some have established programs linking teen-agers and senior citizens, such as one in which high school juniors and seniors make daily calls to shut-ins.

Others have taken older teens on wilderness survival trips in order to give them a sense of their own worth and competence, Ms. Bell said.

"They run from big things to very, very small things," she said. "We encourage people to start small, experience some success, then move on."

Evesham's "Adopt A Cop," program allows nine- and ten-year-olds to become familiar with law enforcement officials in a non-threatening, casual way.

"A sergeant goes into the fifth graders (twice a year and answers questions such as 'Have you ever used your gun?' and 'Do you lock up children?' " said school board member Pat Hibbs.

She noted that fifth grade was chosen because younger children found it hard to relate to the police officers, and "older than that, they're not receptive, they're already hardened."

The SCOP team in Evesham was also instrumental in creating a Rap Room where adolescents and teens could drop in to discuss problems at home or school. Staffed by volunteers, the room is located in a renovated old house on Maple ave. and offers a place where teens can find a friendly ear, Mrs. Hibbs said.

A Primary Prevention Program, by which classroom teachers seek to identify adjustment problems in youngsters as young as six and seven, has been implemented in Gloucester Township.

According to George Bigge Jr., principal of the Glendora School there and member of the six-person SCOP team, its purpose is to look for withdrawn and poorly adjusted children — before they become withdrawn and poorly adjusted teenagers.

"If left unattended, these are problems that will build, and by junior high school, having been left to fester and grow, will need even greater help," Bigge said.

Children singled out for attention work with classroom aides in what the principal described as "an easy, comfortable environment." The goal is to build a youngster's trust in adults and change the negative way in which he views himself.

Although it is difficult to measure the success of a program such as SCOP, as Barbara Bell acknowledged — "If you are preventing something, how do you measure something that has not occurred?" she said — the state official said one yardstick is the number of ongoing programs townships report.

Of 70 municipalities undergoing the original training, 65 have active teams, Ms. Bell said.

*Keansburg action program....*

# Involve community in drug abuse program

MAYORS AND PRAISERS: As Community Concepts Action Program continued its fight against drug and alcohol abuse in the Keansburg schools, Mayor Walter Farley, left, and Edward Murphy, head public counselor, talk to a pupil at the high school.



136

Rec'd from Roselle 12-17-81

# Dramatic reduction told on costs of vandalism

By J.W. BURNETT

A dramatic reduction in the costs of vandalism against the Roselle Park school system was reported at Tuesday night's board of education meeting.

From July 1979 through November 1980, the board paid $2,789 in repairs which resulted from vandalism. For the same period in 1980-81, the figure rose to $7,091, due mostly to one incident, a robbery at the high school.

During the robbery [illegible] from a sink in the science ro[illegible] turned on. The water ran all [illegible] and soaked through the floor, damaging the room beneath it and a copying machine there.

This year, however, vandalism costs for the same period amounted to only $621. Ernest Finizio, superintendent of schools, credits the change to the vandalism program.

In his report to the board, Finizio outlined 14 projects to stop and prevent vandalism in schools during the day, at night and during holidays. Each project is geared to student involvement and commitment.

"What we've been trying to do is develop pride in self and pride in the community," said Finizio. To that end, the program focuses upon prevention and intervention, attempting to lower the incidence of drug and alcohol abuse.

"If students have pride in themselves, they don't need alcohol and drugs," said Finizio, pointing to the improved vandalism statistics.

The program began in 1975, with the training of school personnel at Adelphi University, under a federal grant. The trained staffers then set up the "Roselle Park Trust Co."

The group combines the staffers and high school students and is the primary vehicle through which the other programs operate.

Programs such as the Halloween Mischief Night Concert, Pride in Self—Pride in Community 2- and 5-mile runs, leadership development classes in the high school and a Big Brother-Big Sister program, are run by the trust company.

Finizio points to the Mischief Night Concert as a particular success. "Five hundred people were at the concert this year," he said, "and we had no damage mischief night in Roselle Park. They want the concert."

Another part of the effort against vandalism involved meeting with trouble-making students to find out why they committed the acts.

Some students, which Finizio described as hardcore, said they just wanted to be out of school even if thrown out. Others acted more out of frustration with the school system.

The latter group of students, composed of those often suspended or given detention for troublesome but not serious acts, is now put on Saturday suspension, that is, they must do their time on Saturdays, when everyone else is off from school.

# Roselle Park High School staff gets a taste of the wilderness

Eighteen staff members from Roselle Park High School returned from a day in the wilderness early during this school year with an increase of self-confidence as well as trust and respect for their co-workers.

The staff boarded a yellow school bus and journeyed to Wild Cat Mountain, Hewitt, where they rappelled a 40-foot cliff, scaled a 10-foot wall and fell four feet into each other's arms. The activities were part of a workshop designed by Urban and Suburban Environments (USE) with the purposes of improving communication and trust, and enhancing the problem-solving skills of the staff.

Upon arrival, the teachers got their first taste of the wilderness when they discovered that "the choice was the outhouse or the deep woods," according to Fran Moffett, staff member.

The first in a series of problem-solving activities was to "escape the imaginary pygmies across a river of molten peanut butter," Moffett said. "The only escape route was a cargo net hung some 10 feet in the air between trees. The staff devised an ingenious plan to move the reluctant and somewhat antiquated bodies of the staff into the air and on to the cargo net which they then descended via a somersault on the other side to reach terra firma once more — an eternity below," she said.

The group then moved deeper into the woods for additional challenges and soon arrived at the site of a former charcoal furnace. "Here group trust was tested, as one by one, the staff ascended the wall and fell backwards into the waiting arms of the group. The four-foot wall forced each person to place his trust in his colleagues and in their ability to protect him. Everyone came through unharmed and with growing confidence in both himself and his fellow staff members," Moffett said.

A short hike through the woods brought the group to the site of the next challenge — a 10-foot wall. They were asked to figure out how to get over the wall and down the other side by using only each other's bodies for aid. "One person took a running jump and made it to the top with the help of others pushing him. Then others got to the top and helped the rest by reaching down ... Most of the group was able to reach the summit. The hardest job was the very last person to go over the wall. There was no one left below to push him, but many willing hands reached down to help pull him up," she said.

After that victory, the group walked through the woods to a great rock. The guide then asked the teachers how they would find the their lunches that they left behind, early in the hike. During their discussion, the group eventually came up with a theory which led to their lunches and hardhats, which would later be used for their cliff adventure.

A strenuous hike eventually led to the cliff. After the group climbed to the top of the mountain, they were rewarded with the opportunity to sit down and have lunch. "Feet and other assorted body parts were beginning to make themselves known at this point for some less-in-shape staff members," Moffett said.

After lunch, the group faced "the most fearsome challenge of all," which they looked forward to with "great trepidation," according to Moffett. The group was asked to rappel off the edge of a 40-foot cliff. "A harness was used to hold frightened bodies in safety as they plunged down the cliff. Two different ropes were set up to accept the harnesses of two different people. One person was anchored to a tree and retained a rope that could help a person in danger and a third person fed the rope out to the second person ... The entire staff braved the cliff and successfully made it to the bottom, with no heart attack and no one missing in action," she said.

After the group hiked back to the base camp, they gathered in a circle and commented about the day's adventures. "The general feeling seemed to be that it was challenging, stimulating, frightening and rewarding in many ways," Moffett said. The staff was told that it was the first faculty group in the state to participate in this workshop at Wild Cat Mountain.

Funding for the trip was provided by the Board of Education and the Roselle Park Trust Company, the school district's drug and alcohol prevention project. Throughout the year, various groups comprised of students, police officers and staff members will venture to Wild Cat Mountain for similar experiences.

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NASADAD ALCOHOL AND DRUG ABUSE REPORT

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TABLE OF CONTENTS

FISCAL BENEFITS OF SUBSTANCE ABUSE PREVENTION PROGRAMS

Page

Executive Summary . . . . . 1

Introduction . . . . . 1

The Statewide Community Organization Program . . . . . 2

Four Exemplary Statewide Community Organization Programs . . . . . 3

- Community One . . . . . 3
- Community Two . . . . . 4
- Community Three . . . . . 5
- Community Four . . . . . 6

Assessing Fiscal Benefits of Substance Abuse Prevention Programs . . . . . 6

Results . . . . . 8

- Community One . . . . . 9
- Community Two . . . . . 10
- Community Three . . . . . 11
- Community Four . . . . . 12

Discussion . . . . . 12

Conclusion . . . . . 13

References . . . . . 14

Table 1. Summary of Fiscal Benefits . . . . . 15

Appendix: Data Sources . . . . . 16

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## Executive Summary

In addition to an incalculable amount of human suffering, there is also a large economic cost directly related to the abuse of psychoactive chemicals. The most recent estimates of this economic burden (for 1977) is an annual cost of $66 billion for the United States. While the primary focus in the evaluation of substance abuse prevention programs must be on their ability to promote health and well-being, it is also important to assess the economic benefits of such programs. This study examines the economic benefits associated with substance abuse prevention programs operating in four New Jersey communities.

The four communities received their training in prevention through the New Jersey Statewide Community Organization Program (SCOP). In the SCOP training, a team of school and community leaders are trained in prevention and intervention strategies, and how to foster positive social climates that encourage personal growth in youth. Such social climates encourage youth to select productive, self-satisfying uses of time, rather than self-destructive activities such as substance abuse. The teams also learn group problem-solving skills and methods for mobilizing community resources to develop prevention activities. Brief descriptions of the activities undertaken by the teams in the four communities are included.

Standard cost benefit methods are used in estimating the monetary benefits of the prevention programs. The calculations are made using the local community as the recipient of the benefits. Four major types of monetary benefits to the local community were identified: (1) increases in school attendance, (2) decreases in school vandalism, (3) provision of alternative services for high risk youth, and (4) increased volunteer services. The monetary value of school attendance was assessed according to current expenditures for per pupil instruction. Vandalism cost reductions were simply taken from the appropriate school budget line items. The fiscal values of alternative services for high risk youth were assessed in terms of reduced demand for the more expensive conventional services for troubled youth. The fiscal value for increased volunteer services was estimated by multiplying the increase in hours of volunteer services by the minimum wage.

Fiscal values were estimated only for the year following the SCOP training. (Data were not available for doing multiple year estimates for all of the four programs.) Since the effects of the training undoubtedly carry over for additional years, the estimates of total fiscal benefits must be considered very conservative.

An increase in school attendance was found in one community with an estimated value of $23,280. Decreases in school vandalism were found in three communities with an estimated total value of $11,000. Increases in volunteer services occurred in three communities with an estimated value of $17,782. Alternative services for high risk youth were established in all four communities with an estimated total value of $170,400. The costs of providing training ranged from $4,000 to $8,000 per team. Benefit/cost ratios ranged from a low of 6.9 to 1 to a high of 12.1 to 1.

This application of standard cost benefit techniques to the four substance abuse prevention programs in New Jersey shows that even the short term fiscal benefits to the communities are much greater than the monetary costs of the training. Cost benefit analysis cannot be a comprehensive evaluation for a service as complex as substance abuse prevention, but in the four communities studied it clearly indicates that SCOP training has been a very productive social investment.

## Introduction

One does not ordinarily associate substance abuse prevention programs with monetary outcomes. Substance abuse prevention services are properly concerned with health and well-being, not in making money. It would be a fundamental distortion of these services to consider them primarily from a fiscal perspective.

At the same time it is clearly inappropriate to ignore fiscal benefits of substance abuse prevention programs. The most recent estimate of the economic costs of substance abuse in the United States was $65.8 billion for the year 1977 -- $49.4 billion for alcohol abuse and $16.4 billion for other drug abuse. (Cruze, Harwood, Kristiansen, Collins and Jones, 1981). This included costs of providing treatment for substance abuse itself, treatment for related medical disorders, lost productivity and criminal justice system costs for drug related crime, among other factors. It did not include the costs of goods stolen to support a drug habit. Given the size of the economic cost to society of various forms of substance abuse, it is important to examine the fiscal benefits of substance abuse prevention programs.

This study is an exploratory examination of the fiscal benefits of substance abuse prevention programs in four communities in the State of New Jersey. The general logic of cost-benefit analysis (Mishan, 1976; Thompson, 1980) was used, including deriving a benefit/cost ratio for the activities in each community.

The communities were not selected on a random basis, but rather from those known to have a well functioning prevention program and sufficient data for the study. They include urban, suburban, and rural areas, but do not necessarily represent all communities that have substance abuse prevention programs in New Jersey. A study that would include a scientifically representative sample of programs is currently being planned.

The positive outcomes of prevention programming were assessed in monetary terms whenever possible. These monetary benefits were then compared to the fiscal costs of the prevention programs. It should be emphasized, however, that this study should not be used as a full cost-benefit analysis for comparing these prevention programs to other types of programs. First, there were a number of "intangible" benefits, such as changes in attitudes and self concept that could not be assigned monetary equivalents. Second, there were other benefits of the programs that could have been assigned monetary values, but the data for making the necessary estimates were not available.

Despite these limitations, the fiscal benefits in a single year exceeded the related cost of the prevention programs for each of the four communities.

This report consists of four sections. The first section, describing the general prevention approach of Statewide Community Organization Program teams throughout the State of New Jersey, is followed by a second section with more specific descriptions of the actual programs in the four communities in this study. Third, the methods for assigning monetary values for identified benefits of the programs are explained, and fourth, these methods are applied to actual data from the four communities.

## The Statewide Community Organization Program

In 1967, the Federal government, through the Department of Health, Education and Welfare funded a nation-wide effort to promote the prevention of drug abuse among the nation's youth. Under this grant, the Adelphi University National Training Institute (AUNTI) was established in the northeastern United States. AUNTI served as a training program in which teams of school and community leaders learned basic prevention and intervention strategies to combat drug use among youth.

In 1973 and 1974, two separate groups of school and community leaders from "Community One" were trained by the AUNTI program. Neither of these teams remained intact. From out of these two teams, however, there emerged a single unified team. The activities of this new team produced dramatic results in the school district. These results were presented in 1977 to the State of New Jersey and to the United States Senate Subcommittee on Alcoholism and Drug Abuse Education.

In 1979, the New Jersey Office of Prevention of the Division of Narcotic and Drug Abuse Control initiated the Statewide Community Organization Program (SCOP). The intent of the project was to train and assist teams of New Jersey school and community leaders in developing and implementing programs for the promotion of positive adjustments among youth and the entire community. The State of New Jersey contracted with the Community One team as exclusive trainers and consultants to SCOP teams. Subsequently, numerous teams have received SCOP training and have joined together to form a network of prevention programs. There are currently over seventy New Jersey communities in the SCOP network.

Each SCOP team participates in an intensive three day training workshop, which includes a combination of didactic and experiential seminars. School and community leaders learn prevention and intervention strategies. They are trained to foster a positive social climate suitable for personal growth of students. Planning and decision making skills are presented to equip the SCOP teams to mobilize school and community resources needed for the development of drug abuse prevention activities.

Abuse of drugs is assumed to be one of a number of self-defeating, negative responses to emotional pain. SCOP contends that by presenting the youngster with accurate information in a supportive environment, and by fostering positive attitudes toward himself and others, the individual is less likely to turn to drugs as the solution to distress. An individual would more likely apply his or her knowledge and make an intelligent decision to manage life stress without resorting to chemical substances.

The funding and manpower needed to plan and operate programming is a major concern. SCOP programs need not cost taxpayers large amounts of money. When funds and resources for program operations are needed, SCOP teams are trained to raise funds and mobilize untapped resources. Such an attitude maximizes the creativity and energy of staff and students.

The SCOP training does not advocate that the same types of programs and projects be conducted in each community that sends teams for training. Rather, each team is encouraged to assess the particular problems in its community and the resources it has to solve those problems. Thus, the specific activities carried out by a SCOP trained team vary considerably from community to community. The next section will describe the activities that resulted from the SCOP training in the four communities in this study.

## Four Exemplary Statewide Community Organization Programs

### Community One

Community One is a suburb in northern New Jersey. It is primarily a middle and working class, white area. During the early 1970's the community perceived a problem of high drug use and vandalism rates among its youth. This led to the initial training. Three major projects were developed from this training.

The team established an Outward Bound program in the community for high school aged youth. The program involves survival training in the wilderness culminating in a five day wilderness trip. The Outward Bound training emphasizes development of self confidence and teamwork as a basis for survival in a wilderness setting. The experiences in Outward Bound are sufficiently challenging that the self-confidence and teamwork skills developed in the program carry over into the home community. A final aspect of the Outward Bound program in Community One is that each participant spends four days in various forms of community service after returning home.

The Outward Bound program is offered to one hundred and twenty youths per year. Half of the youth selected are "high risk"—youth who have already shown some difficulties in school or with authorities. As a result of their participation in Outward Bound, the high risk youth typically improve in school attendance and academic standing, and reduce involvement with juvenile justice authorities.

One example of the type of influence this Outward Bound Program has on its participants concerns a youth who was drinking very heavily. His parents had tried for two years to get him to join Alcoholics Anonymous, but he had successfully resisted. The peer pressure and concern shown by his fellow participants in Outward Bound led this youngster to join and find help at AA.

The second major project instituted by the SCOP team in Community One was the Primary Mental Health Program. This program operates in the elementary schools, serving children from kindergarten through the third grade. The services are provided to students experiencing difficulties in school. They are an alternative to referring the children to a Child Study Team for assistance. Parents from the community are trained and supervised by the school psychologist to provide the services in the Primary Mental Health Program. Approximately 60 children per year receive services in this program.

The final project that was instituted by the team in Community One involves youth providing services to the elderly. Each school day, twenty high school youth spend fifteen minutes telephoning senior citizens in the community. The telephone calls provide a means of checking for any problems the senior citizens may be having, as well as an important means of linking the senior citizens to others in the community, and thus avoiding social isolation.

This third project is an excellent example of that part of the SCOP philosophy that focuses on youth providing services to others. Substance abuse and other problems of youth are not to be resolved merely by providing services to youth. It is also important to have youth actively provide meaningful service to others. The sense of being needed and appreciated is a powerful antidote to the sense of alienation that increases substance abuse among youth.

**Community Two**

Community Two is located in an inner city neighborhood of a large city in northern New Jersey. The neighborhood is not devasted in the sense of certain parts of the South Bronx in New York City. It still contains a number of small businesses and good housing stock.

The population consists of lower middle class, working class and "working poor" persons as well as persons below the official poverty line. The community is predominantly Hispanic, with only small numbers of whites and blacks.

Two teams from Community Two received SCOP training in the fall of 1980. The strategy adopted by these teams was to organize community members to develop services and activities from within the community, rather than importing them from the outside. The predominantly Hispanic nature of the community was a major aspect of this strategy. The Hispanic culture provides certain strengths that can be drawn upon, and also creates special needs in terms of relating to the larger English based culture.

One of the strong themes in Hispanic culture is concern for the children. This can be seen in the fact that approximately eight hundred parents come to the local elementary school each day to "present their child to the teacher." The SCOP teams have utilized this concern as a way of integrating the parents with the English based bureaucracy of the school. One of the team members meets monthly with groups of parents. He serves as a communication channel between the parents and the school. Because of his efforts, the parents have acquired a better understanding of how the school functions as a formal organization and how they may obtain their objectives by working within the system. An example of this was a parent who was able to place a son into the local university-based high school.

Parents are also actively contributing to the day to day operation of the school. An average of seven parents per day volunteer two and one-half hours of time in the school. They perform a variety of tasks: from operating mimeograph machines to supervising homework centers to working in special classes.

The academic program of the school has also been strengthened. Senior citizens have been recruited to provide tutoring four hours per week to twenty-five students, with special emphasis on tutoring in English. The school has also instituted a "gifted and talented" section for selected students that is taught in Spanish.

Another major emphasis of the SCOP team at the elementary school has been after school recreation for the students. The lack of recreational opportunities has been a long term problem for the community and was one of the perceived reasons for the involvement of youth in substance abuse. As a result of SCOP team efforts, programs were instituted in baseball, basketball and swimming. Local businesses and community organizations such as the Hispanic Association and the YMCA have supported these recreational programs through donations of their facilities and monies. Community members also donated their time to serve as coaches for the various teams. Funds are provided to cover the costs of participating students who cannot afford the fees or equipment involved. Special efforts are made to involve students having behavior problems in school. Teachers have reported improvement in student behavior as a result of student participation in the recreational programs.

Efforts have also been organized to improve the physical aspects of the school and the neighborhood. "Project Paint" was organized to paint over the graffiti that had been

sprayed on the school walls. Community members repainted the school walls, and new graffiti has not appeared on them. The lack of new graffiti can be seen as a result of the increased community pride in the Community Two school. Another aspect of the improvement in the physical part of the neighborhood was the formation of a committee to get the city government to raze two dilapidated buildings near the school. The dilapidated buildings were clearly fire hazards as well as detractions from the physical appearance of the neighborhood.

An additional part of the SCOP teams' efforts at the Community Two school has been to have a local community center "adopt" the school. The community center opened and continues to make available all of its facilities to the school. A major program that has been started is a series of adult education courses that are offered in the evenings at the center. English as a second language is one of the more popular courses offered.

Community Two is certainly not affluent by any monetary standard. The neighborhood has the usual problems associated with low income levels. Despite these probems, the neighborhood has a rich reservoir of community spirit. The SCOP teams have successfully articulated this community spirit and channeled it into a great variety of activities and services.

**Community Three**

Community Three is predominantly white, middle class and is located in east-central New Jersey. Fourteen percent of the approximately 30,000 population is black, and welfare recipients as well as the very affluent live in the area. Almost 20 percent of the population is of school age.

The SCOP team was trained in Community Three in December, 1980. The team includes two school administrators, two law enforcement officers and two community officials. This team has affected their school and community through developing several significant programs. Student involvement in school and community activities has grown. Changes in student participation are reflected in various school, crime and community indices. Four of the major programs implemented by this SCOP team are described below.

The Student Leadership Training Weekend is an annual program run over the Labor Day weekend. The first weekend run in 1981 included 48 students, 6 teachers and the 6 SCOP team members. The goal of the weekend was to develop a sense of common purpose among the students, and to combat a general lack of school spirit. The thrust of the weekend activities was team work and peer leadership. This was accomplished through team games and sports encounters that required trust, creativity and cooperation among students and staff. Funding for this program was raised through community contributions and donations.

The Contract System for Juvenile Delinquents Program was developed to decrease vandalism in the schools and teach delinquents a sense of justice and community responsibility. This program was implemented in 1981 with the full cooperation of the local police department and criminal justice system. The program is seen as an alternative to family court for selected local juvenile delinquents arrested for crimes committed against property. The focus of the program is to offer the young offender a contract to render services to the community in lieu of criminal prosecution. It is hoped that instead of making the delinquent more angry and bitter towards authorities, a sense of community pride and responsibility may be fostered.

The Beware Of A Stranger Program was developed to decrease the incidence of harm, injury and abduction of young children in the community. The target population is children in grades K through 2. The police department, in cooperation with the schools, developed film and slide presentations teaching the children about safety and prevention of potential problems.

The SCOP team is currently working on a film series program to address the problem of community apathy and lack of participation. The goal of this program is to mobilize families and community to enrich the lives of their children and the life of the community.

**Community Four**

Community Four is a small rural community located in southern New Jersey. It is predominantly white, with lower to middle income families. The SCOP team was trained in October, 1980. The team includes one school administrator, two law enforcement officers, and two community leaders. The primary focus of the team's work has been with school children in grades K through 8. The Primary Prevention Program was designed to meet the special needs of high risk children.

The Primary Prevention Program was developed to identify and provide services to disciplinary problem children. These children would have ordinarily been referred to a Child Study Team. The program was funded through a Federal grant awarded to the team in 1981. Teachers in grades K through 3 were taught to identify troubled children and refer them to the program's special services, which are provided by trained parents from the community. Only severely disruptive, disturbed children are now referred to the Child Study Team. The Primary Prevention Program has a capacity of 30 children. Since the inception of the program, referrals to the Child Study Team have dropped. School administrators and professionals on the Child Study Team have been able to give fuller attention to their other functions and responsibilities.

Future SCOP team programs include a survey of the drug and alcohol abuse problem in the school and community and implementation of programs to prevent drug abuse among all youth groups within the community.

## Assessing Fiscal Benefits of Substance Abuse Prevention Programs

Assessing the economic benefits of substance abuse prevention programs would seem to be relatively simple. The economic costs of drug abuse (including alcoholism) have been reasonably well estimated (Cruze et al, 1981). They involve lost employment, treatment, increased medical problems, and increased criminal justice costs among other factors. That prevention programs can successfully increase knowledge about drugs, change attitudes toward drug use, and actually reduce drug usage among persons who have started to use drugs is well documented (see Schaps, DiBartolo, Palley and Churgin, 1978).

Given our current state of knowledge, however, it is not possible to estimate the number of persons who did not become substance abusers as a result of participating in a prevention program. The research needed to estimate this number of persons has not been conducted for both practical and theoretical reasons. The length of time one can be "at risk" of becoming a substance abuser is very long. Generally, a person can be considered at-risk of becoming a substance abuser up through age twenty-five (Kandel, 1978). If a person has not used drugs regularly before twenty-five, he or she is unlikely to become a

substance abuser. (The period during which one is at risk of becoming an alcoholic is not as clearly defined as for illicit drugs, but is is undoubtedly longer than up to age twenty-five.) Because most people who participate in prevention programs do so in their early adolescence, a study that would follow a group of participants to determine how many became substance abusers would necessarily be a very long and expensive study.

Even if the needed data were to be collected, there would still be great difficulties in interpreting it. There are many factors in addition to drug prevention programs that influence whether or not a person becomes a substance abuser. There are also many factors that probably serve to either increase or decrease the effects of a prevention program upon an individual. Trying to sort out these numerous causes and interactions would be an exceedingly difficult theoretical task at best.

While it is not currently possible to estimate the numbers of persons who do not become substance abusers as a direct result of prevention programs, it is possible to assess the monetary values of other outcomes of prevention programs. During the relatively long time period during which one becomes a substance abuser, the person typically experiences other difficulties in life. These may include problems relating to peers and parents, problems in school, troubles with legal authorities, lack of constructive uses for leisure time, and a general sense of alienation from the community. Often chemicals will be used as an attempt to cope with some of these problems. Such attempts are very rarely successful, and while they may make the person feel better in the short run, they usually will increase the problems over time. Thus, a vicious cycle can occur in which drugs are used in an attempt to cope with other problems, serving to make the problems worse, and leading to additional drug use.

Drug abuse prevention programs often focus on reducing these antecedent problems as a long range means of reducing substance abuse. It is often possible to assess the "monetary value" of these problems rather directly in terms of what the community is willing to spend to resolve them. This is the major way in which it is currently possible to assess the economic benefits of drug prevention programming.

Before considering specific details of assessing economic value, it is important to ask, "Economic value to whom?" There are three different levels of analyses (Rossi, Freeman and Wright, 1979). The first is that of the individual – what are the economic gains and costs to the individual person who may participate in the program? The second level is that of the organization conducting the program – what will be its economic gains and costs? The final level is that of the society as a whole. At this level, economic benefits and costs are analyzed in terms of how a particular program will effect the gross national product, the sum of all goods and services produced within a society. The economic costs of substance abuse and alcoholism that were mentioned earlier (Cruze et al, 1981) were calculated from this societal level. If it were possible to estimate the number of persons who were prevented from becoming substance abusers through prevention programs, it would be appropriate to use the societal perspective also.

For this study we have used the organizational level of assessing economic benefits. Thus, the benefits are assessed in terms of the specific organizations that conduct the programs. In this case, it is the different communities that participate in the SCOP training and then mount prevention activities that utilize their training. The actual costs of the SCOP training are incurred by a different organization, the New Jersey State government. In order to "transfer" this cost to the organization that is receiving the benefits, it is necessary to consider the case where the State government offered the local communities the choice between the SCOP training or a cash payment equivalent to the cost of the training. The essence of this benefit/cost analysis can be phrased as "What

are the fiscal benefits of SCOP training to the local community compared to the 'forgone opportunity' of refusing a cash grant equivalent to the cost of the training?"

Four different types of economic benefits from SCOP training are assessed for each of the communities in this study: increased school attendance, reduced school vandalism, reduced demand on other youth services, and increased volunteerism.

Truancy from school is clearly a contributing factor in substance abuse, and attending school clearly has a positive economic value for persons in our society. The exact size of this positive economic value is a matter of some debate, depending how much of future earning differences are attributed to education. For the purposes of this study, the economic value of a day in school was measured in terms of what the local school district is spending to provide education. The value of a day at school for one student is simply calculated by dividing the school budget for a given year by the number of students enrolled, and then by the number of days in the school year. This method produces a smaller economic value than using future earnings, but it is more easily related to immediate community expenditures.

Reduced school vandalism is by far the easiest value to assess. Almost all schools have vandalism repairs as an item in their budgets, and the economic value can be assessed by the reductions in those budgeted vandalism costs.

The assessment of reduced demand for other youth services is relatively straightforward. Society provides a number of interventions that are intended to alleviate problems among youth. These include juvenile court systems and, within the New Jersey schools, "Child Study Teams." The Child Study Team is typically composed of school administrators, school psychologists, medical personnel, social workers and learning disability specialists. The team works with students who are experiencing difficulties in school. The cost of providing these services to youth can be calculated from the salaries of the personnel composing the team and the percentage of their time that is devoted to the Child Study Team. To the extent that demand is reduced for such youth services as Child Study Teams, drug prevention activities can provide fiscal benefits to the community. (The fiscal benefits are realized through the personnel on the Child Study Team finding other productive use of their time.)

Increased volunteer services in a community is an indication of greater community cohesion. Such cohesion is associated with low rates of substance abuse. This, of course, is in addition to the direct benefits of the volunteer services. Assessing the monetary value of volunteer services is usually done through estimating what it would cost to hire people to perform the same work. It is not possible to do this for the wide range of volunteer services associated with the SCOP trained teams. Instead we will use the minimum wage of $3.45 per hour. This produces a very conservative estimate of the economic value of the volunteer services.

## Results

The economic impact of the programs implemented by each of the four SCOP teams was assessed in five different areas: (1) average annual school attendance, (2) vandalism towards school property, (3) services to "special children," (4) services available through volunteerism, and (5) miscellaneous services. Estimations of all fiscal savings to the local community attributed to each SCOP team are used to compute a benefit/cost ratio for each SCOP team.

Community One

- Attendance. Attendance did not change in the Community One schools as a result of SCOP team activities. The teams were trained in 1973 and 1974. The average annual attendance rates during the years prior to and after SCOP team training remained about the same, varying around the 92% mark for the school district.

- Vandalism. Vandalism in the school district did drop significantly after the SCOP training. Vandalism had been rising in the years prior to the SCOP team training, reaching $15,000 in the year immediately preceding the training. Vandalism costs fell to $8,000 in the year after the training, and have been slowly rising since. They have not yet reached the pre-training levels. Given the pattern of this data, we would attribute the $7,000 reduction in vandalism costs in 1973-74 to the impact of the SCOP team's efforts.

- High Risk Youth Services. The Primary Mental Health Program was the major alternative service program instituted in Community One as a result of the training. This program serves youth having difficulties within the school system and is an alternative to sending the child to the Child Study Team for services. The cost per child serviced in the Primary Mental Heath Program was $318, while the cost per child served by the Child Study Team was $3,162, a difference of $2,844. The major factor in this cost difference is the salaries of trained parents working in the Primary Mental Health Program ($5.50 per hour) and the salaries of the members of the Child Study Team, which are typically over $30,000 per year. Assuming that 30 of the 60 children who received assistance from the Primary Mental Health Program during the first year of operation would have otherwise received services from the Child Study Team, a total fiscal benefit of $85,320 was achieved.

- Volunteer Services. High school students in Community One performed volunteer service in a SCOP team program set up to telephone senior citizens. Students would contact senior citizens to provide them with social contact, detect problems of the senior citizens, and lend assistance. Twenty youth spent an average of 15 minutes per day in this activity, before the start of each of the 180 school days. Valuing student labor at the minimum wage of $3.45 gives a total of $17.25 per day of volunteered labor, or over the school year, a total of $3,105.

- Miscellaneous. The Outward Bound Program is an annual leadership training program that costs the SCOP team an estimated $8,700. Benefits from the program, such as improved self esteem, improved facility-student relationships and more effective student leaders, cannot easily be valued in terms of dollars. However, after the leadership training weekend, each of the 120 participants of the program volunteered 24 hours of their time to community service. If these students were paid at the minimum wage of $3.45, the total salary costs for these services would amount to $9,936. Thus the donated services of the students of the Outward Bound program exceeds the monetary cost to operate the program by $1,136.

- Total Benefits. The dollar savings to the school attributable to the efforts of the SCOP team thus totals $96,661. This financial benefit was accrued over the first full year of operation of the SCOP team in 1973-74. Financial benefits attributable to the operation of SCOP team programs in subsequent years are not included, though they most assuredly would be substantial. The total cost of training was $8,000. (Two teams were trained, they then coalesced into a single team.) The benefit/cost ratio for the Community One team is thus 12.1 to 1. This is a measure of the return received for investing money in the training of these SCOP teams. For

every dollar spent training the Community One teams in 1973-74, $12.10 was generated in savings or services within the community.

Community Two

- Attendance. The average annual attendance at the Community Two elementary school has slowly and steadily improved over the last five school years, from 86.9% in 1977-78 to 92.1% in 1981-82. For the four years prior to SCOP training, the increase in attendance was between .8% and 1% per year.

  The SCOP teams were trained in the fall of 1980, and began implementing their programs that school year. The first year of full operation was the school year of 1981-82. Attendance increased by 2.5% in 1981-82, more than twice the increase in any of the preceding four years. It thus seems reasonable to attribute part of the attendance increase in 1981-82 to the activities of the SCOP teams. We would attribute 1.5% of the 2.5% increase in 1981-82 to the activities of the SCOP team. This is the difference between the actual increase of 2.5% and the highest increase for any of the previous four years.

  An increase of 1.5% in attendance, applied to the average enrollment of 1142 students in Community Two elementary school, produces an increase of 17.13 child-years of attendance. The cost of educating one child at the school for one year was $1,359. Multiplying the increase in child-years attended by cost of educating one child for one year produced a total of $23,280. This is the amount of money "saved" by the SCOP team through increased attendance. This money would have otherwise been spent without children receiving the benefits of instruction.

- Vandalism. With the implementation of the student school painting project, school wall graffiti and other forms of vandalism decreased. Estimating from the previous year's vandalism costs, the project prevented $2,500 worth of vandalism.

- High Risk Youth Services. The Senior Citizens Tutorial Program served the needs of "special" children requiring further academic assistance. Twenty-five senior citizens tutored children one-to-one, four hours per week over the 36 week school year. These senior citizens were volunteers and not paid for their services. If these citizens were to be paid at the minimum hourly wage of $3.45, the total tutorial program would have cost $12,420 in salaries. Since the tutorial services were donated, these costs were saved.

- Volunteer Services. The Mother Aide Program included 7 mother volunteers who worked 2½ hours per day (180 days per school year). If these mothers were to be paid at the minimum hourly wage of $3.45, the Mother Aide Program would cost $10,867.50 in salaries. Since this is a donated service made available through the SCOP team efforts, these costs are saved.

  Organized sport programs were supervised and operated by volunteer coaches. Throughout the school year, 10 coaches offers 3 hours each week for 24 weeks to work with school children. If these coaches were to be paid at the minimum hourly wage of $3.45, the recreational programs would cost $2,484 in salaries. Since these services are donated, these costs are saved.

- Miscellaneous. The existence of dilapidated buildings adjacent to the school building presented a fire hazard and a place for drug trafficking. The SCOP team project to have the government raze the vacant old buildings near the school saved the school

an estimated $4,000 that would have been required to raze the buildings had the community done it on its own.

- Total Benefits. The dollar savings to the school attributable to the efforts of the SCOP team thus totals $55,552. The cost of training the two teams was $8,000. The benefit/cost ratio for Community Two, is thus 6.9 to 1. For every dollar spent training the Community Two SCOP teams, they generated $6.90 in savings or services for their community.

Community Three

- Attendance. Comparison of the average annual attendance in the Community Three school district between the school year prior to the SCOP training (1980-81) and the school year immediately after the training (1981-82) showed a slight decrease in attendance, from 95% to 92.5%. School officials attribute this drop in attendance to the reorganization of the high school and junior high school during the 1981-82 school year. Effects of the SCOP team training were thus confounded with the impact of the school district reorganization, and the potential impact of SCOP activities upon improving attendance cannot be easily assessed. No improvements in attendance can be attributed to SCOP activities.

- Vandalism. Malicious vandalism costs decreased from $5,500 in 1980-81 to $4,000 in 1981-82. This savings of $1,500 is assumed to be the result of activities of the SCOP team.

- High Risk Youth Services. The Contract System For Juvenile Delinquents is an alternative program to family court for certain juveniles involved in the law for their first time, and who allegedly perpetrated a crime against property. Costs to local police and the family court to process one juvenile, based on average hourly wages of a Community Three police officer and the estimated costs of processing a juvenile case through the Family Court System, are estimated to be $971. In contrast, the cost to the local police to process a juvenile through the Contract System is estimated to be $17.00. The difference in costs is $954. In the first year of this program's existence, 40 juveniles were placed on contracts. Assuming that 30 of these 40 youth would have otherwise been processed through the court system gives a savings of $28,620 due to the Contract System. In addition, juveniles in the Contract System are required to donate an average of 10 hours of their time to community service. If these 40 juveniles were to be paid for their work at the minimum wage of $3.45, their community service would be worth $1,380. Thus the total benefit from this program is estimated at $30,000.

- Volunteer Services. The Student Leadership Training Weekend is a leadership training program that is operated on an annual basis. The first training weekend was held in 1981 and was fully sponsored by donations. Along with 48 students, 6 teachers and the 6 SCOP team members attended the training weekend. An estimated minimum of 384 hours of volunteer time was needed for organizing and carrying out this training weekend. Assessing the financial donation of volunteer time at the minimum wage of $3.45 would give an estimate of approximately $1,325.

- Miscellaneous. Insufficient data was available to assess the financial impact of the Beware Of A Stranger Program.

- Total Benefits. The total dollar savings to school community attributable to the efforts of the SCOP team of Community Three in the 1981-82 school year is $38,825. The cost of training the team is $4,000. The benefit/cost ratio for this SCOP team is 8.2 to 1. This means that for every dollar spent in training this SCOP team, the team generated savings or services to the community worth $8.20.

**Community Four**

- Attendance and Vandalism. Virtually no changes were observed in attendance and vandalism costs between the school year prior to SCOP team training (1980-81) and the school year after training (1981-82). The attendance was already very high, 95% and the vandalism costs very low, $600.

- High Risk Youth Services. The Primary Prevention Program in Community Four is fashioned after the Primary Mental Health Program of Community One. Costs and financial savings accrued by this alternative program to the Child Study Team are similar. The Primary Prevention Program similarly served 30 children in its first year of operation. Assuming that half of these children would have otherwise been served by the Child Study Team gives an estimate of fiscal savings to the school district of $42,660.

- Volunteer and Miscellaneous Services. None exist at this time.

- Total Benefits. The fiscal savings to Community Four attributable to the efforts of the SCOP team totals $42,660. Cost of training was $4,000. The cost-benefit ratio for the Community Four team is thus 10.7 to 1. This means that for every dollar spent in training this SCOP team, the team generated savings or services worth $10.70 to the community.

## Discussion

At this point it is worth repeating that this is an exploratory study applying cost benefit analysis to substance abuse prevention programs in New Jersey. The purpose of the study was to provide a first order estimate of the fiscal benefits that could reasonably be attributed to SCOP teams in four communities. The communities were selected as having well functioning SCOP teams, and are not necessarily representative of all SCOP teams in the State.

It should also be added that the study was not done to compare the different SCOP teams in the different communities. A comparison of prevention activities should include much more than the fiscal benefits of the teams' efforts.

Table 1. presents a summary of the fiscal benefits for the four SCOP teams examined in this study. The fiscal benefits were calculated for the first year after the SCOP training and thus are clearly very conservative estimates. Certainly the volunteer activities and programs like the Community One Primary Mental Health Program can be expected to continue and provide benefits for many years. If one assumed the effects of the SCOP training to last four years, the estimates of the fiscal benefits would be multiplied by a factor of 3.5. (A discount rate of 10% is used in this calculation. See Mishan, 1978, pp. 176-81, for a discussion of using discount rates to obtain the present value of benefits occurring in the future.)

Of the various types of fiscal benefits examined in this study, an increase in school attendance was found in one of the four communities. Attendance was already high in the other three communities (well over 90% in each) and it appears that SCOP training does not lead to improvements where school attendance is already quite high. In the community where the training does appear to have increased as a result of the SCOP training, however, the fiscal benefit is substantial. Given the expense involved in providing public education, even small improvements in attendance are fiscally important.

Reductions in vandalism costs occurred in three of the four communities. Vandalism costs were already quite low in the other community, where the team efforts were centered on an elementary school. Reductions in vandalism costs typically occurred in high schools and/or where such costs were high. The reductions did not involve large amounts of money, but were still significant compared to the $4,000 cost for training one SCOP team.

Volunteer services were established in three of the four communities. The fiscal benefits of these services were established in three of the four communities. The fiscal benefits of these services were estimated using the minimum wage of $3.45 per hour. Even using this conservative estimate of the value of the volunteer services, their fiscal value was considerable in comparison with the costs of the training.

Alternative services for high risk youth were established as a result of SCOP training in all four communities. The size of these estimated fiscal benefits is directly linked to the relatively high costs of the pre-existing services — Child Study Teams and Family Courts. An important area of uncertainty in estimating the fiscal benefits of the SCOP teams is in the assumptions regarding how many of the youth who received the alternative services would have otherwise received the more traditional services. The assumptions used here were based on discussions with the SCOP team personnel and were meant to be conservative.

## Conclusion

Fiscal benefits are not commonly associated with substance abuse prevention programming. The present study was undertaken to examine fiscal benefits of Statewide Community Organization Program training. The fiscal benefits were estimated from the perspective of the participating school community. Substantial fiscal benefits were found in all four types considered: improved school attendance, reduced vandalism, volunteer services, and alternative services for youth. Even when the estimation of benefits was limited to only one year after training, the fiscal benefits were many times greater than the costs of training.



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Table 1.

Summary of Fiscal Benefits

| Category | Community One | Community Two | Community Three | Community Four |
|---|---|---|---|---|
| Attendance | $ - | $23,280 | $ - | $ - |
| Reduced Vandalism | 2,500 | 1,500 | 7,000 | - |
| High Risk Youth Services | 25,320 | 12,420 | 30,000 | 42,660 |
| Volunteer Services | 3,105 | 13,352 | 4,325 | - |
| Miscellaneous | 1,236 | 4,000 | - | - |
| Total | $96,661 | $55,352 | $32,825 | $42,660 |

## Appendix: Data Sources

Descriptions of the programs and activities of the SCOP teams in the different communities were obtained from interviews with team members and from documentation filed by the teams with the New Jersey Department of Health.

Estimates of the costs of providing services for a child through the Child Study Team and through the Primary Mental Health Program were provided by the Assistant Superintendant of the school district in Community One. They were based on the salaries of personnel in the Child Study Team and in the Program, and on the number of children served per year. Since the Primary Prevention Program in Community Four was based on the Primary Mental Health Program in Community One, the same cost estimates were used.

It was not possible to obtain direct data for estimating the court processing costs for assessing the fiscal benefits of the Contract System for Juvenile Delinquents. An estimate of $900 was obtained for average court costs per arrest in New York State (State Plan Update, 1982, New York State Division of Substance Abuse Services). The additional $71 per youth was based on police time per for attending court and was furnished by the youth officer in the Community Three police department.

Costs of training for SCOP teams were furnished by the New Jersey Department of Health, and included costs for trainers and Department of Health staff members who oversee SCOP training.

### Statement of Walter J. McCarroll

My name is Walter J. McCarroll and I am an assistant commissioner for education in the New Jersey Department of Education. Prior to assuming my present position in June of 1983, I served as superintendent of schools in two New Jersey school districts for a period of 16 years. During my career as a public school administrator, both at the local level and now in the State department of education, I have been actively involved in the development and implementation of substance abuse prevention programs for young people. On the basis of this experience, I am convinced that the most effective drug and alcohol abuse programs are those that involve the total community in their development and implementation.

The problems attendant to young people in a community are not just school problems. They are a community problem in which the schools must play a major role. In my view, the development of effective education prevention programs requires the acknowledgement, the interest and the commitment of the total community. If we are to make a difference in resolving this problem, we must establish programs that marshal the resources of all of those in the community who contribute to a plan to resolve the problem. This collective effort, the very basis of the SCOP program in New Jersey, involves the schools, law enforcement officials, municipal officials, churches, parents and students.

On a larger scale, this same collaborative effort must prevail between the State and local level and among appropriate departments at the State level. In this vein, I would like to explain the cooperative efforts that presently exist between the New Jersey Department of Education and the New Jersey Department of Health.

The New Jersey Department of Education and the New Jersey Department of Health are engaged in a cooperative effort to provide assistance to school districts that wish to implement services which address the problem of student drug and alcohol use. The current level of cooperation has grown out of a long shared concern regarding substance abuse in the public schools. For a number of years, agreements between the two departments have resulted in a series of cooperative efforts: New Jersey Alcohol Education Network (1978–80); State task force on drug and alcohol in schools (1979); New Jersey smoking and health project (1979–80); Statewide Community Organization Program (1978–83); joint committee on drug and alcohol education guidelines (1981); survey of drug and alcohol use among New Jersey public high school students (1981); and Statewide Inservice on School Substance Abuse Programs (1981–83).

In the current fiscal year, a similar interdepartmental agreement is in effect which provides the basis for assistance now being provided to school districts. The

intent of the agreement was further emphasized when, in September 1983, commissioner of education, Saul Cooperman, included a substance abuse initiative among his priorities for the department of education. As a result, staff within the department were assigned to the task of providing information resources and training designed to assist school districts in the establishment of programs for the prevention of student drug and alcohol use. To this end, a planning task force with membership consisting of assistant commissioners and staff from both the Department of Education and the Department of Health was convened in October 1983. The discussions held by the task force resulted in the articulation of strategies for assisting districts as well as the strengthening of the departments' resolve to take effective action on the issue. Responsibility for planning and implementation of the strategies identified by the task force was then assigned to an interdepartmental project team. Within the Department of Education, the team drew upon staff from both the regional curriculum services units and the division of general academic education. The department of health was represented by staff from both the division of narcotics and the division on alcoholism.

In March 1984, Commissioner Cooperman again reiterated the Department's intention to deal with student substance abuse when he and Governor Thomas Kean announced the urban initiative. Among the nine major issues to be addressed in urban school districts is included "the establishment and continuation of programs for the prevention and treatment of drug and alcohol use."

The activities included in the present interdepartmental effort are:

1. DESK REFERENCE MANUAL ON STUDENT DRUG AND ALCOHOL USE: A COMPREHENSIVE PLANNING GUIDE FOR SCHOOL ADMINISTRATORS

This document will be distributed to chief school administrators and building principals in September 1984. It offers both a planning process and the resources needed for developing and implementing effective services. It also provides the framework for the training, technical assistance and consultative services provided to districts by both the Department of Education and the Department of Health. A directory of various local, county and regional agencies that provide assistance to schools or direct services to students is also included.

2. PROGRAM MODELS FOR THE PREVENTION, INTERVENTION AND TREATMENT OF STUDENT SUBSTANCE ABUSE

Designed as a companion piece to the desk reference manual, this doucument describes a number of programs from throughout New Jersey and the Nation that can serve as models for districts. The programs, organized on the basis of whether they are prevention, intervention or treatment oriented, are described in detail. Names, addresses and phone numbers of contact persons are also provided. The programs included in this publication were selected by a panel consisting of staff from the Department of Education and the Department of Health.

3. REGIONAL SUBSTANCE ABUSE PLANNING FORUMS

These sessions are designed to assist districts which have acknowledged the need to institute substance abuse services. The content of the sessions is directed toward administrative and supervising staff. Specifically, the sessions have five objectives:

To assist the district's leadership team in better defining the substance abuse problem they wish to confront;

To assist the district in the initial conceptualization of a plan appropriate for their district;

To familiarize the district with the information and training resources that are available through the Department of Education, the Department of Health, and various country and local agencies;

To identify a limited number of districts which will make a commitment to program development during the 1984–85 school year by participating in a pilot implementation probject (described below); and

To enable the Departments of Health and Education to gain a better understanding of districts' perceptions of the problem and obstacles to the implementation of substance abuse services.

The first round of regional fourms was held in May 1984, at the three regional curriculum services units. A second round is planned for October, 1984.

#### 4. PILOT IMPLEMENTATION PROJECTS

Pilot implementation projects are a collaborative effort between the Department of Education and limited number of school districts for the purpose of developing effective substance abuse services. Districts undertaking pilot implementation projects in the 1984–85 school year will receive targeted training and information services from the Department of Education and Health. The assistance provided districts will be of a prolonged and intensive nature consisting of the training of leadership personnel, planning assistance, evaluation assistance, consultative services, and brokering to outside resources. Districts will develop implementation and evaluation plans to guide their program development efforts. The department will assist in the collection and analysis of evaluative data. Districts that are shown to be effective after one year of full implementation will be eligible for consideration as a State certified model program. Programs certified as models must be shown to be effective during a second year of full implementation using an evaluation design approved by the Department of Education.

#### 5. STATEWIDE INSERVICE ON SCHOOL SUBSTANCE ABUSE

The Statewide Inservice Program is a continuation of activities initiated in 1981 as a result of agreements between the Departments of Health and Education. It is designed to increase awareness of school substance abuse related issues and to provide short term training to shcool personnel regarding substance abuse services. Its services have been offered to a large number of districts each year leading to the implementation of substance abuse strategies in schools throughout the State.

#### CONCLUSION

The task of providing effective programs for the prevention of substance abuse among our young people is among the most complex and challenging problems to face our society today. Programs to address this problem must be creative, well planned and properly financed. However, the single most important ingredient that is necessary for the development of effective substance abuse prevention programs is the cooperation between and among all of those at the local and State level who have a contribution to make.

The involvement of the Federal Government is a necessary part of the overall plan to combat substance abuse. It is my view that the Federal Government must continue to express an interest in the development and implementation of effective substance abuse prevention programs, provide leadership in coordinating the efforts of the States in these projects, and establish financial support, particularly in the area of research, for prevention programs.

Thank you for providing me with an opportunity to express may view in this most important subject.

### APPENDIX A—FISCAL YEAR 1983 SUBCONTRACTS RECOMMENDED FOR FUNDING BY CONTRACTORS

Contractor: Midwest Region; BRASS Foundation (300–79–0525) Chicago, Illinois.

| School district | Contact or coordinator | Urban/rural | Budget |
|---|---|---|---|
| 1. Board of Education, 228 N. La Salle St., Chicago, IL. | Madeline Bucker (contact) 312/641–4563. | Urban: 1HS; 3 JHS | $13,721 |
| 2. Batesville Community Schools, P.O. No. 121, Batesville, IN. | Jerry Brelage (contact) 812/934–4384. | Nonurban: 1 HS; 1 JHS | 9,190 |
| 3. North East Community School District, No. 1 School Lane, Goose Lake, Iowa. | Marvin Boyer (contact) 319/577–2449. | Nonurban: 1 HS; 1 JHS | 9,967 |
| 4. Mason City Community Schools, 1515 S. Penn. Ave., Mason City, Iowa. | Ronald M. Rice (contact) 515/423–7249. | Nonurban: 1 HS; 3 JHS | 16,313 |
| 5. Bedford Public Schools, 1575 W. Temperance Road, Temperance, MI. | Eleanore J. Gordon (contact) 313/847–6736. | Nonurban: 1 HS; 1 JHS | 10,069 |
| 6. Cape Girardeau Public School District No. 63, 61 N. Clark Avenue, Cape Girardeau, MO. | Norman Schwav (contact) 314/355–6654. | Nonurban: 1 HS; 1 JHS | 10,640 |
| 7. Educational Service Unit No. 1, 301 Main Street, Wakefield, NB. | Larry D. Clay (contact) 402/287–2077. | Nonurban: 2 HS; 1 JHS | 12,832 |
| 8. Mitchell School District No. 17–2, 117 E. Fourth Street, Mitchell, SD. | Robert W. Boone (contact) 605/996–6671. | Nonurban: 2 HS; 1 JHS | 17,040 |

| | School district | Contact or coordinator | Urban/rural | Budget |
|---|---|---|---|---|
| 9. | School District of Bayfield, P.O. Box 1, Bayfield, WI. | Dr. Ronald Anderson (contact) 715/779–3201. | Nonurban: 1 HS; 1 JHS | 10,225 |
| 10. | Milwaukee Public Schools, 5225 W. Vliet Street, Milwaukee, WI. | Phil Haddix (contact) 414/475–8059. | Urban: 2 HS; 2 JHS | 14,708 |
| 11. | Menominee Indian School District, P.O. Box 399, Keshena, WI. | Wanda G. Richards (contact) 715/799–3841. | Nonurban: 1 HS; 1 JHS | 7,295 |
| | Alternates | | | |
| 1. | Monroe County Community Schools, 315 North Drive, Bloomington, IN. | David Ebeling (contact) 812/339–3481. | Nonurban: 2 HS; 2 JHS | 11,019.70 |
| 2. | Des Moines Independent Community School District, 1800 Grand Avenue, Des Moines, Iowa. | Wesley Chapman (contact) 515/284–7781. | Urban: 1 HS, [illegible] JHS | 23,211 |
| 3. | Stevens Point Area Public Schools, 1900 Polk Street, Stevens Point, WI. | Emery Babcock (contact) 715/346–2461. | Nonurban: 2 HS; 2 JHS | 14,992 |

Contractor: Northeast Region, Adelphi University (300–79–0527) Sayville, New York.

| | School district | Contractor or coordinator | Urban/nonurban | Budget |
|---|---|---|---|---|
| 1. | Montgomery County Public Schools, 850 Hungerford Drive, Rockville, MD. 20850. | Dr. Richard Towers (contact) 301/279–3246. | Urban: 2 HS; 2 JHS | $21,688 |
| 2. | Burlington School District, 14 Williams Street, Burlington, VT 05401. | Pasquale De Lego (contact) 802/863–4521 (x240). | Urban: 2 HS; 2 JHS | 16,507 |
| 3. | Nashau School District, No. 6 Main Street, Nashua, NH 03060. | Carol Farland (contact) 503/889–5400 (x41). | Nonurban: 1 HS; 3 JHS | 19,960 |
| 4. | Barnstable Public School, 230 South Street, Hyannis, MA 02601. | H. William Geick (contract) 617/771–2211. | Nonurban: 1 HS; 1 JHS | 10,012 |
| 5. | West Milford Board of Education, No. 46 Arnold Road, West Milford, NJ 07480. | Daniel Mullen (contact) 201/697–1700. | Nonurban: 1 HS; 1 JHS | 8,632 |
| 6. | North Babylon U.S. School District, No. 5 Jardine Place, North Babylon, NY 11703. | Joyce Flynn (contact) 516/367–9626. | Nonurban: 1 HS; 1 JHS | 12,668 |
| 7. | Agarwam Public Schools, 1305 Springfield Street, Feeding Hills, MA 01030. | James Brun (contact) 413/789–1400. | Nonurban: 1 HS; 1 JHS | 10,330 |
| 8. | Columbiana County Joint School District, 9364 State Route 45, Lisbon, OH 44432. | Jospeh Smith (contact) 216/424–9561. | Nonurban: 1 HS; 1 JHS | 10,184 |
| 9. | Portsmouth School District, Clough Drive, Portsmouth, NH 03801. | Porter J. Schoff (contact) 603/431–5080. | Nonurban: 1 HS; 1 JHS | 10,052 |
| 1. | Youngstown Board of Education; 20 West Wood Street, P.O. Box 550, Youngstown, OH 44501. | Audrey Neale (contact) 216/743–1151 (x304). | Urban: 2 HS; 2 JHS | 26,223 |
| 2. | Dayton Board of Education School District, 348 West First Street, Dayton, OH 45402. | Dr. William H. Goff (contact) 513/461–3086 or 3087. | Urban: 2 HS; 2 JHS | 22,724 |
| 3. | Trumbull Public Schools, 6254 Main Street, Trumbull, CT 06611. | Dr. John Mulrain (contact) 203/268–5388. | Nonurban: 1 HS; 2 JHS | 13,390 |
| 4. | Randolph Public Schools, Highland Avenue, Randolph, MA 02368. | Thomas C. Lane (contact) 617/963–7800 (x43). | Nonurban: 1 HS; 2 JHS | 14,392 |

Contractor: Southeast Region, University of Miami (300–79–0523) Coral Gables, Florida.

| School district | Contact or coordinator | Urban/nonurban | Budget |
|---|---|---|---|
| 1. Metro Nashville Davidson County Public Schools, 2601 Bransford Avenue, Nashville, TN 37204. | Dorothy Barrick (coordinator) ..... Lucille Nabors 615/259–8655..... | Urban: 2 HS; 2 MS..... | $12,150 |
| 2. Charleston County School District, Hudson & Meeting Sts., Charleston, SC 29403. | Meleanee Williams (coordinator). Rod Spaulding (contract) 803/722–8461. | Urban: 2 HS; 2MS ..... | 15,596 |
| 3. Greensboro Public Schools 712 North Eugene St., Greensboro, NC 27402. | Lemuel H. Cox (coordinator) 919/378–9981. | Urban: 2 HS; 2 JHS..... | 14,810 |
| 4. Board of Education County of Taylor, P.O. Box 160, Grafton, WV 26354. | Gary C. Hollingshead (coordinator) 304/265–2497. | Nonurban: 2 HS; 1 MS ..... | 14,302 |
| 5. Clarksville Montgomery County Schools, 501 Franklin, Clarksville, TN 37040. | Willie C. Cowan (coordinator) 615/648–0257. | Urban: 2 MS; 2 HS..... | 11,862 |
| 6. Griffin-Spaulding County School System, P.O. Drawer N., Griffin, GA 30224. | A. Russell Gray (coordinator) 404/227–9478. | Nonurban: 1 JHS; 1 HS..... | 7,668 |
| 7. Baker County School District, 392 S. Blvd. E., Macclenny, FL 32063. | Carol Pittman (coordinator) 904/328–8811. | Nonurban: 1 HS; 1 MS ..... | 8,906 |
| 8. Haywood County Schools, 1615 N. Main St., Waynesville, NC 28786. | Ernestine Upchurch (coordinator). Samuel Smith (contact) 704/456–8613. | Nonurban: 2 HS ..... | 6,377 |
| 9. Birmingham Board of Education, 2015 Park Pl. N., Birmingham, AL 35218. | Elizabeth Hatch (coordinator)..... James Young (contact) 205/879–3353. | Urban: 1 HS; 2 MS; 1-Elem (1–8). | 14,546 |
| Alternates | | | |
| 1. Winston-Salem, Forsyth County Schools, Winston-Salem, NC. | Dr. Marcia Epstein, 919/727–2374. | Urban: 3 HS; 1 JHS ..... | 14,714 |
| 2. Fairfax County Schools, Fairfax, VA..... | Bernard Cameron, 703/691–3204. | Urban: 4 HS..... | 17,828 |
| 3. Madisen County Board of Education, Huntsville, AL. | Lynn Halladay, 205/532–3533.... | Nonurban: 1 HS; 3 JH; 1 Elem (K–3). | 19,099 |

Contractor: Southwestern Region, Center for Educational Development (300–79–0527) San Antonio, Texas.

| School district | Contact or coordinator | Urban/nonurban | Budget |
|---|---|---|---|
| 1. Paradise Valley Unified School District, 3012 E. Greenway Road, Phoenix, AZ 85032. | Jane A. Northup (coordinator) 602/992–3563. | Urban: 3 HS..... | $14,484 |
| 2. Conway Public Schools, Highway 60 West, Conway, AR 72032. | Dr. Bobby New, assistant superintendent (contact) 501/329–5630. Virginia Nutter (coordinator) ..... | Nonurban: 1 HS; 1 JHS; 1 MS..... | 15,104 |
| 3. Colorado Springs District No. 11, 1115 N. El Paso St., Colorado Springs, CO 80903. | Wayne Stegman (contact)..... Ralph Kruger (coordinator)..... | Urban: 3 HS; 1 JHS..... | 17,542 |
| 4. Caddo Parish School Board, P.O. Box 37000, Shreveport, LA 71130. | Richard Thompson (coordinator) 318/636–0210 (x365). | Urban: 4 HS..... | 19,262 |
| 5. Albuquerque Public Schools, 725 University, SW, Albuquerque, NM 87125. | Sara Sue Steed (coordinator) 505/842–3731. | Urban: 1 HS; 3 MS..... | 17,042 |
| 6. Los Alamos School District, P.O. Box 90, Los Alamos, NM 87544. | J. Denny Holder (coordinator) 505/662–4141. | Nonurban: 1 HS; 2 JHS..... | 10,485 |
| 7. Levelland Independent School District, 1103 Houston, Levelland, TX 79336. | Gene E. Davenport (coordinator) 806/894–9628. | Nonurban: 1 HS; 1 JHS; 1 MS..... | 10,740 |
| Alternates | | | |
| 1. Santa Rosa Consolidated Schools, 344 4th Street, Santa Rosa, NM 88435. | Dr. Benjamin Coca (contact) 505/472–3395. | Nonurban: 1 HS; 1 MS; 2 ES ..... | 12,212 |
| 2. Carbon County School District, Drawer B, Price, UT 84501. | "J" Frank Warthen (contact) 801/637–1041. | Nonurban: 2 HS; 2 JHS..... | 12,742 |

| | School district | Contact or coordinator | Urban/nonurban | Budget |
|---|---|---|---|---|
| 3. | Jefferson County Public Schools, 1209 Quail Street, Lakewood, CO 80215. | Roica Horning (contact) 303/231-2361. | urban: 1 HS; 2 JHS | 19,262 |

Contractor: Western Region, Awareness House (300-79-0524) Oakland, California.

| | School district | Contact or coordinator | Urban/nonurban | Budget |
|---|---|---|---|---|
| 1. | Coachella Valley Unified School District, 87225 Church St., P.O. Box 847, Thermal, CA 92274. | Frank W. Howard (coordinator) 619/399-5929. | Nonurban: 1 HS; 1 JHS | $8,097 |
| 2. | Blackfoot School District No. 55, 400 West Judicial, Blackfoot, ID 83221. | Elliott L. Moeser (superintendent of schools) (coordinator) 208/785-2424. | Nonurban: 1 HS; 1 JHS | 10,171 |
| 3. | Central Valley School District No. 356, South 123, Bowdish Road, Spokane, WA 99206. | William J. Hoppes (coordinator) 509/922-6738. | Nonurban: 1 HS; 1 JHS | 8,001 |
| 4. | Johnson County School District No. 1, Buffalo, WY. | Von P. Dahl (coordinator) 307/684-9571. | Nonurban: 1 HS; 1 JHS | 9,730 |
| 5. | Mt. Diablo Unified School District, 1936 Carolotta Drive, Concord, CA 94519. | Raphael R. Bellumini (coordinator) 415/682-8000 (x347). Harney Wall (contact/negotiation) 414/682-8000 (x252). | Urban: 3 HS; 1 JHS | 16,220 |
| 6. | Tacoma School District No. 10, P.O. Box 1357, Tacoma, WA 98401. | Therese Destito Peterson (coordinator) 206/572-6110. | Urban: 1 HS; 3 JHS | 15,085 |
| 7. | Scappoose School District No. 1, P.O. Box V, Scappoose, OR 97056. | Richard H. Hart (coordinator) 503/543-6374. | Nonurban: 1 HS; 1 JHS | 6,055 |
| 8. | Orange Unified School District, Orange, CA. | Jane McCloud (coordinator) 714/997-6348. | Urban: 2 HS; 2 JHS | 15,990 |
| 9. | Great Falls Public Schools, P.O. Box 2428, 1100 4th Street, South, Great Falls, MT 59403. | Kenneth W. Kelly (coordinator) 406/791-2297. | Nonurban: 1 HS; 1 JHS | 8,436 |
| 10. | School District No. 271, 311 N. 10th Street, Coeur d' Alene, ID 83814. | Warren R. Bakes (coordinator) 208/664-8241. Douglas R. Cresswell (contact, negotiation) 208/667-4507. | Nonurban: 2 HS | 7,201 |
| 11. | West Valley High School, 9206 Zier Road, Yakima, WA 98908. | Donald L. Cox (coordinator) 509/965-2000. | Nonurban: 1 HS; 1 JHS | 5,275 |
| | Alternates | | | |
| 1. | Clark County School District, Las Vegas, NV. | Ronald G. Ross (coordinator) 702/649-0707. Dr. D.L. Bundren 702/736-5231. | Urban: 1 HS; 3 JHS | 13,330 |
| 2. | Oakland Unified School District, Oakland, CA. | Fred B. Foston (coordinator) 415/836-8140. John Lievare, associate superintendent (contact) 415/836-8186. | Urban: 1 HS; 3 JHS | 10,946 |
| 3. | Albany Unified School District, Albany, CA. | Shirley Haverfeld (coordinator) 415/526-6441. Craig Bayan (contact) 415/526-6441. | Nonurban: 2 HS | 6,038 |
| 4. | Chino Unified School District, Chino, CA. | Barbara Merrill (coordinator) 714/628-1201 (x279). Dr. Bud Davis (contact) 714/628/1201 (x272). | Nonurban: 1 HS; 1 JHS | 6,930 |
| 5. | Corvallis School District, Corvallis, OR. | Margo D. Garton, assistant to superintendent (coordinator) 503/757-5852. | Nonurban: 1 HS; 1 JHS | 7,354 |

| | School district | Contact or coordinator | Urban/nonurban | Budget |
|---|---|---|---|---|
| 6. | Mercer Island School District, Mercer Island, WA. | Wm. R. Bleakney (contact) 206/233-3302. | Nonurban: 1 HS; 1 JHS..... | 8,375 |

APPENDIX B

BETH ISRAEL MEDICAL CENTER,
*New York, NY, June 26, 1984.*

Hon. CHARLES B. RANGEL,
*Chairman, Select Committee on Narcotics Abuse and Control, House of Representatives, Washington, DC.*

DEAR CONGRESSMAN RANGEL: Thank you again for the opportunity to testify today before your Committee. I enclose at this time the admission forms of Beth Israel's Methadone Treatment Program which I was asked to submit.

The length of my testimony notwithstanding, the only issue of any consequence is the one which you yourself posed: what can one tell a member of the community who seeks treatment for heroin dependence? Until we can direct such people—and there are tens of thousands of them across the country—to immediately available services, nobody concerned about the problem of addiction can be satisfied. The answer which we are obliged to give today—place your name on a "list" and continue to shoot dope for six weeks or six months until a space becomes available—is a cruel joke.

Finally, I would reiterate that the goal of treatment on demand is not nearly as elusive (or costly) as it might appear. As just one example, if the Federal Government demanded as a prerequisite for participation in the Medicare and Medicaid programs that each hospital provide short-term out-patient detoxification to a modest number of patients, the problem would be solved instantaneously.

Sincerely yours,

ROBERT G. NEWMAN, M.D.,
*General Director.*

## INTRODUCTION AND ORGANIZATION

### Beth Israel Medical Center
### Methadone Maintenance Treatment Program

BACKGROUND

Since 1964 Beth Israel Medical Center has operated the largest voluntary Methadone Maintenance Treatment Program in the United States. Following the principles outlined by Drs. Marie Nyswander and Vincent Dole for the treatment of heroin addiction with methadone, Beth Israel Medical Center currently treats almost 7,000 patients and records over 900,000 visits annually.

Beth Israel Medical Center pioneered the concept that drug addiction treatment should take place within the community, and therefore established formal affiliation agreements with major hospitals and medical centers throughout New York City. The goal of this treatment network is to provide comprehensive medical and supportive services to our patients. Each of the Program's clinics treats from 150 to 300 patients.

Methadone maintenance treatment has proven to be an effective modality for the treatment of heroin addiction. Research conducted over the past ten years has shown that methadone patients function within a range consistent with that of the population as a whole, and that methadone does not impair a person's ability to function normally in educational, vocational, and social pursuits.

GOALS AND OBJECTIVES

The effective functioning of the Beth Israel Medical Center Methadone Maintenance Treatment Program is based on the following premises:

1. That methadone maintenance treatment will be available to each and every eligible addict in New York City who voluntarily seeks this modality of treatment.

2. That appropriate pharmacological support will be provided through individualized doses of methadone, taken orally, in order to eliminate the craving for heroin and other morphine-like drugs, and to establish a high degree of cross-tolerance to the effects of all narcotics.
3. That patients who present health problems will be treated in their clinics, and referred when indicated for specialized health services at the affiliate hospital or another appropriate facility.
4. That effective supportive services will be provided to all patients who want and need assistance in the following areas: social, mental health, legal, vocational rehabilitation, education, counseling, socialization and leisure time activities, in an effort to increase the functioning of our patients and to provide them with the skills necessary to lead a productive and personally satisfying life.
5. That we will attempt, in so far as we are able, to influence public policy concerning the acceptance of methadone treatment as a viable modality.

ORGANIZATION OF BIMC/MMTP

1. Each clinic is an integral part of the Beth Israel Medical Center Methadone Maintenance Treatment Program network, and shall adhere to the policies and procedures of Beth Israel Medical Center as well as those set forth by the Program Administrator.
2. Each clinic shall be staffed with personnel capable of providing the full range of rehabilitative services. Staff orientation and in-service training and education shall be provided by the Program Central Office. Although flexibility of treatment approaches is encouraged, changes in overall treatment approach shall not be carried out without the approval of the Program Administrator and the Chief of Medical and Psychiatric

LOG # _____ DATE _____

**BETH ISRAEL MEDICAL CENTER**
**METHADONE MAINTENANCE TREATMENT PROGRAM**

**Application Form**

Please answer all questions. If you do not understand any item, please see _____ for assistance. All information is strictly CONFIDENTIAL.

1. Full Name _____ (FIRST) (FIRST NAME) (MIDDLE NAME) (LAST NAME)
2. Home Address: _____ (NUMBER AND STREET)
   _____ Zip. _____ (APT NO) (C/O) (CITY AND STATE)
3. Mailing Address: _____ (IF DIFFERENT) (NUMBER AND STREET OR P.O. BOX)
   _____ Zip: _____ (APT NO) (C/O) (CITY AND STATE)
4. Telephone No.: _____ 5. Social Security # _____
6. Date of Birth: _____ 7. Mother's first name: _____
8. In what year did you first use heroin? _____
9. In what year did you begin using heroin on a daily basis? _____
10. Are you currently addicted?
    Yes — Heroin — How Frequently? — Daily
    No — Street Methadone — Less Often
11. Are you currently enrolled in any addiction treatment program? Yes No.
    If yes, which one? _____ _____
12. Have you ever been a patient at the Beth Israel MMTP or in Bernstein Institute? Yes No.
    If yes, where and when? _____ _____

---

**Please Do Not Write Below This Line**

Scheduled for screening interview: Date _____ Time: _____ Clinic: _____

Placed on Waiting List - specify: _____

Specify REFERRAL to alternative program: _____

Ineligible - Reason(s) _____

Disposition deferred - Reason(s) _____

_____

Name and title of staff member: _____ Date _____

BIMC 80-87

# BETH ISRAEL MEDICAL CENTER

10 NATHAN D. PERLMAN PLACE, NEW YORK, N.Y. (001)

INTAKE/ADMISSION FORM

MMTP: 006

DATE _____ INTERVIEWER _____

SCREENING DECISION: Accepted for Admission (specify unit) _____

Rejected: _____ Referred (specify agency, if any) _____
(specify reason)

NAME: _____ _____ _____ ADDRESS: _____
(No. and street) (borough) (Zip)

DATE OF BIRTH: / / SOCIAL SECURITY #: TELEPHONE: _____

SEX: MALE ☐ FEMALE ☐ ETHNICITY: B ☐ W ☐ H ☐ A ☐ Other ☐ (Suffix)

MOTHER'S FIRST NAME: _____ MEDICAID NO.:

MARITAL STATUS: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Cmn. Law ☐

HOUSEHOLD COMP: Alone ☐ W/Spouse ☐ W/Other Family ☐ W/Friends ☐ No Stable Arrangement ☐

HIGHEST SCHOOL GRADE COMPLETED: 1-6 ☐ 7-9 ☐ 10-11 ☐ HS Grad ☐ Some Cl. ☐ Cl. Grad ☐

REFERRAL SOURCE: Inst/Agencies ☐ Welfare ☐ Hospital ☐ Court/Police ☐ DTX/Prg ☐
Other Drug Prg ☐ Drug Referral Prg ☐ Family/Friends ☐ Self ☐

WELFARE STATUS: Never Rec'd ☐ No Longer Receiving ☐ Currently Receiving ☐

| CURRENT ACTIVITY | P/T | F/T |
|---|---|---|
| School | | |
| Job/ Skill Training | | |
| Employed | | |
| Homemaker | | |
| Other: specify: | | |

(CHECK ALL THAT APPLY)

IF EMPLOYED: MONTHS ON PRESENT JOB: ☐☐

WHAT OCCUPATION? _____

DRUG USE HISTORY

| | FIRST USE AGE | FIRST USE YEAR | DRUG | CURRENT USE Daily | CURRENT USE Less Often |
|---|---|---|---|---|---|
| | | | HEROIN | | |
| | | | METH (ILLEGAL) | | |
| | | | COCAINE | | |
| | | | BARBITURATES | | |
| | | | AMPHETAMINES | | |
| | | | ALCOHOL | | |
| | | | PLACIDYL | | |
| | | | DORIDEN | | |
| | | | OTHER | | |

PREVIOUS DRUG/ALCOHOL TREATMENT HISTORY:

(Check all applicable)

Drug Free ☐ BIMC MMTP ☐ Other MMTP ☐ Out Pt. Detox. ☐ BIMC DCS ☐ Other Out Pt. Drug Clin. ☐ BIMC ATP ☐

Other Treatment: (specify) _____

Date of Most Recent Discharge from Drug/Alcohol Treatment: _____ Program: _____

Address: _____

TO BE COMPLETED BY OUTPATIENT CLINIC SUPERVISOR

CLINIC _____ Date of First Visit: _____

RUID # (MMTP ONLY) _____ BIMC Medical Record #: _____

If Admitted to BIMC: Date of Admission: _____ Unit: _____

TRIAL FORM 1

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
FOOD AND DRUG ADMINISTRATION

Form Approved
OMB No. 65TR 0098

DATE

# CONSENT TO METHADONE TREATMENT

*(Provisions of this form may be modified to conform to any applicable State law)*

NAME OF PATIENT

NAME OF PRACTITIONER EXPLAINING PROCEDURE

NAME OF PROGRAM MEDICAL DIRECTOR

I hereby authorize and give my voluntary consent to the above named Program Medical Director and/or any appropriately authorized assistants he may select, to administer or prescribe the drug methadone as an element in the treatment for my dependence on heroin or other narcotic drugs.

The procedures necessary to treat my condition have been explained to me and I understand that it will involve my taking daily dosages of methadone, or other drugs, which will help control my dependence on heroin or other narcotic drugs.

It has been explained to me that methadone is a narcotic drug which can be harmful if taken without medical supervision. I further understand that methadone is an addictive medication and may, like other drugs used in medical practice, produce adverse results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive methadone due to the risk of my return to the use of heroin or other drugs.

The goal of methadone treatment is total rehabilitation of the patient. Eventual withdrawal from the use of all drugs, including methadone, is an appropriate treatment goal. I realize that for some patients methadone treatment may continue for relatively long periods of time but that periodic consideration shall be given concerning my complete withdrawal from methadone use.

I understand that I may withdraw from this treatment program and discontinue the use of the drug at any time and I shall be afforded detoxification under medical supervision.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a methadone treatment program, since the use of other drugs in conjunction with methadone may cause me harm.

I also understand that during the course of treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me. I understand that these alternate procedures shall be used when in the Program or Medical Director's professional judgment it is considered advisable.

*(See reverse of this sheet for additional consent elements)*

FORM FD 1633 (12/72)

| FEMALE PATIENTS OF CHILD-BEARING AGE | PATIENTS UNDER 18 YEARS OF AGE |
|---|---|
| To the best of my knowledge, I ___ am ___ am not pregnant at this time.<br><br>Besides the possible risks involved with the long-term use of methadone, I further understand that, like heroin and other narcotic drugs, information on its effects on pregnant women and on their unborn children is at present inadequate to guarantee that it may not produce significant or serious side effects.<br><br>It has been explained to me and I understand that methadone is transmitted to the unborn child and will cause physical dependence. Thus, if I am pregnant and suddenly stop using methadone, I or the unborn child may show signs of withdrawal which may adversely affect my pregnancy or the child. I shall use no other drugs without the Medical Director or his assistants' approval, since these drugs, particularly as they might interact with methadone, may have an e ay unborn child. I shall inform any other doctor who cares me during my present or any future pregnancy or who sees the child after birth, of my current or past participation in a methadone treatment program in order that he may properly care for my child and me.<br><br>It has been explained to me that after the birth of my child I should not nurse the baby because methadone is transmitted through the milk to the baby and this may cause physical dependence on methadone in the child. I understand that for a brief period following birth, the child may show temporary irritability or other ill effects due to my use of methadone. It is essential for the child's physician to know of my participation in a methadone treatment program so that he may provide appropriate medical treatment for the child.<br><br>All the above possible effects of methadone have been fully explained to me and I understand that at present, there have not been enough studies conducted on the long-term use of the drug to assure complete safety to my child. With full knowledge of this, I consent to its use and promise to inform the Medical Director or one of his assistants immediately if I become pregnant in the future. | The patient is a minor, ____ years of age, born, _____.<br>The risks of the use of methadone have been explained to (me/us) and (I/we) understand that methadone is a drug on which long-term studies are still being conducted and that information on its effects in adolescence is incomplete. It has been explained to (me/us) that methadone is being used in the minor's treatment only because the risk of (his/her) return to the use of heroin is sufficiently great to justify this treatment. (I/We) declare that participation in the methadone treatment program is wholly voluntary on the part of both the (parent(s)/guardian(s)) and the patient and that methadone treatment may be stopped at any time on (my/our) request or that of the patient. With full knowledge of the potential benefits and possible risks involved with the use of methadone in the treatment of an adolescent, (I/we) consent to its use upon the minor, since (I/we) realize that otherwise (he/she) shall continue to be dependent upon heroin or other narcotic drugs. |

I certify that no guarantee or assurance has been made as to the results that may be obtained from methadone treatment. With full knowledge of the potential benefits and possible risks involved, I consent to methadone treatment, since I realize that I would otherwise continue to be dependent on heroin or other narcotic drugs.

| | | |
|---|---|---|
| SIGNATURE OF PATIENT | DATE OF BIRTH | DATE |
| SIGNATURE OF PARENT(S) OR GUARDIAN(S) | RELATIONSHIP | DATE |
| SIGNATURE OF WITNESS | | DATE |

DEPARTAMENTO DE SANIDAD, EDUCACION Y ASISTENCIA SOCIAL
SERVICIO DE SANIDAD PUBLICA
ADMINISTRACION DE ALIMENTOS Y DROGAS

Impreso aprobado OMB N°:0378 0094

Fecha

CONSENTIMIENTO AL TRATAMIENTO DE METADONA

(Las disposiciones de este impreso se pueden modificar para conformarlas con cualquier ley estatal pertinente)

Nombre del paciente

Nombre del facultativo que emplea el procedimiento

Nombre del director médico del programa

Por la presente autorizo y otorgo mi consentimiento voluntario al Director Médico del Programa, arriba mencionado, o a cualesquiera ayudantes autorizados que él pueda elegir, para administrar o recetar la droga llamada metadona, como elemento en el tratamiento de mi dependencia de la heroína o cualesquiera otras drogas narcóticas.

Se me han explicado los procedimientos necesarios para el tratamiento de mi condición y entiendo que comprenden la ingestión por mi parte de dosis diarias de metadona, u otras drogas, que contribuirán a controlar mi dependencia de la heroína u otras drogas narcóticas.

Se me ha explicado que la metadona es una droga narcótica que puede ser nociva si se ingiere sin la supervisión médica. Entiendo asimismo que la metadona es una medicación que puede crear hábito y que, lo mismo que otras drogas usadas en la práctica de la Medicina, puede producir resultados adversos. Se me han explicado los métodos alternativos de tratamiento, los posibles riesgos en que se incurre y las posibilidades de complicaciones, pero, no obstante, deseo ser tratado con metadona, debido al riesgo de que pueda volver al uso de la heroína u otras drogas.

El objetivo del tratamiento con metadona es el de la rehabilitación total del paciente. La abstención del uso de todas las drogas, incluso la metadona, es un propósito apropiado del tratamiento. Me doy cuenta de que en algunos pacientes es posible que el tratamiento con metadona pueda continuar por períodos relativamente largos, pero que se considerará periódicamente mi completo abandono del uso de la metadona.

Entiendo que podré retirarme de este programa de tratamiento y suspender el uso de la droga en cualquier momento y que se me proporcionará desintoxicación bajo supervisión médica.

Convengo en que informaré a cualquier médico que me trate por cualesquiera problemas médicos, de que estoy alistado en un programa de tratamiento por metadona, puesto que el uso de otras drogas, en conjunción con la metadona, puede causarme daño.

Entiendo también que en el curso del tratamiento pueden presentarse ciertas condiciones que hagan necesaria la aplicación de procedimientos adicionales o diferentes que los que se me han explicado. Y entiendo que esos otros procedimientos se aplicarán cuando a juicio del Programa, o según el juicio profesional del Director Médico, se consideren aconsejables.

(Véanse al dorso otros elementos en el consentimiento)

FORMA FD 2633 (12/72)



39-324 O - 85 - 11

| Pacientes femeninas en edad de concebir | Pacientes menores de 18 años de edad |
|---|---|
| Que yo sepa, estoy ☐ no estoy ☐ embarazada en este momento.<br><br>Además de los posibles riesgos que envuelve el uso prolongado de la metadona, entiendo que, lo mismo que la heroína y otras drogas narcóticas, lo que se sabe de sus efectos sobre las mujeres embarazadas y en progreso es actualmente insuficiente para garantizar que no producirá efectos secundarios significativos o serios.<br><br>Se me ha explicado y entiendo que la metadona se transmite al niño en gestación y puede ocasionar dependencia física. Por consiguiente, si estoy embarazada y como consecuencia de tomar metadona, yo o el niño nacido podemos presentar síntomas que pueden afectar adversamente mi gestación o al niño. No usaré otras drogas sin el consentimiento del Director Médico o su asistente, puesto que estas drogas pueden combinarse con la metadona y perjudicarme a mí o a mi hijo. Informaré a cualquier médico que me vea durante mi embarazo actual, o cualquier embarazo futuro, o que vea a mi hijo después de nacer, de mi participación actual o anterior en un programa de tratamiento de metadona, para que pueda existirme debidamente a mí o a mi hijo.<br><br>Se me ha explicado que no debo dar el pecho a mi hijo cuando haya nacido porque la metadona se transmite por la leche al niño y puede ocasionar en él dependencia física de la droga. Entiendo que por un breve período después del nacimiento, el niño puede mostrar alguna irritabilidad temporal u otros efectos deletéreos debidos al uso de la metadona por mi parte. Es esencial que el médico del niño esté informado de mi participación en un programa de tratamiento de metadona, con el fin de que pueda administrar al niño el tratamiento médico adecuado.<br><br>Se me han explicado plenamente todos los posibles efectos de la metadona, indicados anteriormente, y entiendo que, actualmente, no se han hecho estudios suficientes sobre el uso de la droga por largo tiempo como para garantizarme la completa seguridad de mi hijo.<br><br>Con pleno conocimiento de todo ésto, consiento en su aplicación y prometo informar inmediatamente al Director Médico o a uno de sus ayudantes si me quedo embarazada en lo futuro. | El paciente es un menor, de _____ años, nacido el _____.<br>Se me han (no nos han) explicado los riesgos que envuelve el uso de la metadona y entiendo (entendemos) que la metadona es una droga que se está suministrando aún y que la información sobre sus efectos en los adolescentes es incompleta. Se me (no nos) ha explicado que el uso de la metadona en el tratamiento del menor se debe solamente a que el riesgo de que recaiga al uso de la heroína es suficientemente grande como para justificarlo. Declaro (declaramos) que la participación en el programa de tratamiento con metadona es completamente voluntaria de parte mía/nuestra (de los) padre (padres) o tutor, y del paciente y que el tratamiento de metadona se puede suspender en cualquier momento a petición mía (nuestra) o del paciente. Con pleno conocimiento de los beneficios potenciales y de los posibles riesgos que envuelve el uso de la metadona en el tratamiento de un adolescente, consiento (consentimos) en su uso en el menor, puesto que me doy (nos damos) cuenta que de otra manera continuará dependiendo de la heroína o de otras drogas narcóticas. |

Certifico que no se me ha dado garantía ni seguridad respecto de los resultados que puedan obtenerse con el tratamiento de la metadona. Con pleno conocimiento de los beneficios potenciales y de los posibles riesgos que envuelve, consiento en el tratamiento de metadona, puesto que me doy cuenta de que, de otra manera, continuaría dependiendo de la heroína o de otras drogas narcóticas.

| | | |
|---|---|---|
| Firma del paciente | Fecha de nacimiento | Fecha |
| Firma de los padres o tutor(es) | Parentesco | Fecha |
| Firma del testigo | | Fecha |

SUBJECT: PATIENT RIGHTS, RULES, AND REGULATIONS

POLICY: The BIMC/MMTP affords to all patients the rights enumerated in the Patients' Bill of Rights, in accordance with New York State Hospital Code.

PROCEDURE:

1. The Patients' Bill of Rights will be prominently displayed in a conspicuous area of each clinic.

2. Each patient shall be advised of these rights and the mechanisms for implementing them.

   2.1. At the intake screening, the interviewer shall explain the rules and regulations of the BIMC/MMTP.

   2.2. All medical procedures and medications prescribed will be described to the patient by the physician or designated medical staff member under the supervision of the physician.

      2.2.1. The patient's informed consent to treatment will be documented in the chart (see Application and Admission Section).

3. At the time of admission, prior to the issuance of the initial dose of methadone, each patient shall receive the handbook, "Beth Israel Medical Center, Methadone Maintenance Treatment Program, Rules and Regulations", in English or Spanish.

   3.1. The contents of the handbook shall be explained to the patient and any questions that the patient may have shall be answered by a staff member assigned by the Unit Supervisor.

   3.2. The patient shall be asked to sign the "Handbook Acknowledgment Form" (BIMC 60-40), attached). The form shall be dated and witnessed by the assigned staff member.

   3.3. The completed "Handbook Acknowledgment Form" shall be placed in the patient's chart.

   3.4. Additional rules and regulations, specific to the patient's clinic, shall be cleared through the MMTP Central Office before becoming part of the handbook. Each additional rule and regulation shall be similarly explained by the staff member and acknowledged by the patient.

   3.5. Each patient shall be familiarized with the rules and regulations which, when violated, can result in discharge from treatment.

1/77 (Rev. 1/83)

4. Patients shall be advised of their rights to file a complaint about any aspect of their treatment.

   4.1. The name of the patient's assigned counselor and the Clinic Supervisor shall be provided to the patient, and the mechanism for requesting appointments shall be explained.

   4.2. The name and telephone number of the MMTP Patient Relations Coordinator shall be provided to the patient.

5. Any problem or question regarding patient rights or a possible violation of them shall be reported immediately to the Clinic Supervisor and the Operations Manager.

(Rev. 1/83)

SERVING THE LOWER EAST SIDE COMMUNITY SINCE 1889

BETH ISRAEL MEDICAL CENTER / METHADONE MAINTENANCE TREATMENT PROGRAM

BETH ISRAEL HOSPITAL • MORRIS J. BERNSTEIN INSTITUTE •
GOUVERNEUR HOSPITAL AFFILIATION • BETH ISRAEL SCHOOL OF NURSING

## Handbook Acknowledgment Form

The undersigned hereby acknowledges receipt of the handbook entitled "Beth Israel Medical Center Methadone Maintenance Treatment Program Rules and Regulations," and further acknowledges that he/she has been informed of the importance of reading and becoming fully familiar with the information contained in the handbook.

Patient _____
Signature

Witness _____
Signature

Date:

RECIBO DE LA GUÍA DE REGLAS Y PROCEDIMIENTOS DEL PROGRAMA DE TRATAMIENTO MEDIANTE SOSTENIMIENTO CON METADONA

El suscribiente, cuya firma aparece abajo, certifica que ha recibido el folleto titulado "Guía de Reglas y Procedimientos del Programa de Tratamiento Mediante Sostenimiento con Metadona del Centro Médico Beth Israel", y que he sido informado de la importancia de leer y familiarizarme con la información que el mismo contiene.

Paciente: _____
(Firma)

Testigo: _____
(Firma)

Fecha de la Firma: _____

BIMC 60-40 (Spanish)

SUBJECT: PHYSICAL EXAMINATION: INITIAL/ANNUAL

POLICY: Each patient of the Beth Israel Medical Center Methadone Maintenance Treatment Program shall receive an initial examination at the time of admission and at annual intervals thereafter.

PROCEDURE:

1. Upon admission each patient shall be given an examination by the unit director, other Program physician or the registered physician's assistant, which shall include a complete medical history and physical examination including a chest X-ray and EKG. A rectal examination shall be done on all patients on admission and annually on all patients over the age of 40. A pelvic examination with Pap smear and GC smear and culture shall be done on all female patients. When these procedures are performed by an R.P.A. all findings and results will be reviewed by the supervising physician and countersigned. It is the responsibility of the unit director to see that any abnormalities found will be followed-up.

   1.1. The physician shall order the tine test. The clinic nurse or the R.P.A. will perform the tine test and read and chart the result and inform the physician of positive results.

   1.2. The tetanus toxoid series shall be ordered by the unit director or other Program physician and will be administered by the clinic nurse or the R.P.A.

   1.3. The results of the medical history and the physical examination shall be recorded by the physician on BDHC Form 60-166 (attachment) and filed in the patient's chart.

   1.4. Laboratory tests and follow-up procedures shall be ordered by the physician in the "Doctor's Orders" section of the patient's chart.

2. The unit supervisor shall be responsible for the coordination of the annual physical examination and laboratory tests.

   2.1. All medical procedures required at the time of admission shall be repeated annually, except for the chest X-ray and EKG which may be ordered when clinically indicated.

11/77 (Revised 2/81)

2.2. The annual physical shall be scheduled during the month of the patient's anniversary date of admission to the BIMC/MMTP. To facilitate scheduling, the MMTP Control Section will prepare and send to each clinic a computer printout, listing those patients who require an annual physical during a given month.

2.3. The clinic nurse shall set up an appointment for the patient to be seen by the unit director, other Program physician or R.P.A.

2.4. The secretary shall prepare an appointment slip for the patient and will complete the forms necessary for all diagnostic tests ordered. The secretary will give the appointment slips to the nurse who will give them to the patient. At the time the slip is given to the patient, the nurse will explain to the patient the importance of the physical examination.

2.5. The secretary shall maintain a tickler file recording the date of the last annual physical examination.

2.6. The nurse shall keep the unit supervisor informed on an ongoing basis of those patients who have not kept their appointments for physical examinations.

2.7. The results of the annual physical examination shall be recorded by the unit director, other Program physician or R.P.A. in the Progress Notes of the patient's chart (attachment).

3. The unit director or other Program physician, the clinic nurse, physician's assistant, unit supervisor, and/or the counselor, at the point of involvement, shall clearly and precisely document the following in the patient's chart: The appointments made and broken, the results of the physical examination and laboratory workup, attempts made by the staff to secure physical examinations for those patients who do not keep their appointments, and any follow-up procedures and treatment.

11/77 (Revised 2/81)

BETH ISRAEL MEDICAL CENTER
METHADONE MAINTENANCE TREATMENT PROGRAM
ADMISSION MEDICAL HISTORY

Patient's Name: _____ RUID: _____ Adm. Date _____

DRUG USE/ABUSE HISTORY

| DRUG USED | Year 1st Use | Date Last Use | Amt/Used Per Day |
|---|---|---|---|
| HEROIN | | | |
| METHADONE (Not Rx) | | | |
| BARBITURATES | | | |
| AMPHETAMINES | | | |
| COCAINE | | | |
| PLACIDYL | | | |
| DORIDEN | | | |
| ALCOHOL | | | |
| OTHER | | | |

PREVIOUS HOSPITALIZATIONS (Specify Dates)

PREVIOUS DRUG ABUSE TREATMENT HX

| Dates (From/to) | Name and Type of Rx Prog. (i.e. Detox, Drug Free ) |
|---|---|
| | |
| | |
| | |
| | |

ALLERGIES:

OBSTETRIC HISTORY:
LMP
# Previous Pregancies
# Live Births
# Miscarriages
# Abortions

FAMILY HISTORY

| Relationship | Alive | Deceased | Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother(s) | | | |
| Sister(s) | | | |
| Husband | | | |
| Wife | | | |
| Children | | | |
| | | | |
| | | | |

Which (if any) relative has had:
Cancer
Tuberculosis
Diabetes
Heart Disease
Hypertension
Stroke
Sickle Cell
Alcoholism
Drug problems

MEDICAL HISTORY (Indicate dates and Rx where appropriate):
CONVULSIONS _____
TUBERCULOSIS _____
SYPHILIS _____
HEPATITIS _____
HEART DISEASE _____
HYPERTENSION _____
RENAL DISEASE _____
ULCERS _____
DIABETES _____
BLOOD DISEASE (Specify) _____
PSYCHIATRIC _____
NOTE: USE CONTINUATION SHEETS FOR ELABORATION OF ANY ITEM OR GENERAL COMMENTS
Histories performed by RPAs must be counter-signed by the Supervising MD

MD/RPA SIGNATURE _____ Date _____
(REVISED 2/81)

Beth Israel Medical Center
Methadone Maintenance Treatment Program
Initial and Annual Physical
Examination Record

Pt. Name _____
I.D.# _____
Admission Date _____

INTERIM PAST HISTORY (Use Admission Medical History form for new patients): _____

DRUG AND MEDICATION HISTORY

REVIEW OF SYSTEMS

HEAD (ENT) _____
NECK _____
BREAST _____
CARDIAC _____
PULMONARY _____
GASTROINTESTINAL _____
OBS/GYN _____
GENITOURINARY _____
MUSCULOSKELETAL _____
EXTREMITIES _____
NEUROLOGICAL _____

PHYSICAL EXAMINATION

GENERAL _____
HEIGHT _____ WEIGHT _____ BP _____ PULSE _____ TEMP _____ RESP _____
SKIN _____
HEAD _____
NECK _____
EYES (pupils, fundi) _____

BMC 60-166 (Rev. 12/82):7 (continue on reverse side)

EARS _____ NOSE _____ THROAT _____

BREASTS _____

CHEST/LUNGS _____

HEART _____

ABDOMEN _____

EXTERNAL GENITALIA _____

PELVIC (Pap Smear/GC culture) _____

RECTAL (patients over 40) _____

NEUROLOGICAL _____

EXTREMITIES _____

LYMPH NODES _____

MENTAL STATUS _____

DIAGNOSTIC IMPRESSION

_____

PLAN _____

LABORATORY TESTS ORDERED:

SMAC [ ] CBC [ ] DIFFERENTIAL [ ] VDRL [ ] ROUTINE URINE [ ]

OTHERS (SPECIFY): _____

MD/RPA SIGNATURE _____ DATE _____